Supreme Court U.S.
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No. _____

IN THE

SUPREME COURT OF THE UNITED STATES

HARRISTON LEE BASS, JR., M.D., Petitioner,
-vs.-
STATE OF NEVADA. BOARD OF MEDICAL EXAMINERS *Respondent*

On Petition for Writ of Certiorari
To the Supreme Court of the State of Nevada

APPENDIX to PETITION FOR WRIT OF CERTIORARI

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IN THE SUPREME COURT OF THE STATE OF NEVADA
Filed June 01 2000
Case No. 30632

HARRISTON LEE BASS, JR., M.D.,)
Appellant/Cross-Respondent,)
vs.)
STATE OF NEVADA, BOARD OF)
MEDICAL EXAMINERS,)
Respondent.)
/

ORDER OF REVERSAL ON CROSS-APPEAL AND ORDER DISMISSING APPEAL

This is an appeal and cross-appeal from district court orders on judicial review of findings by the Nevada State Board of Medical Examiners. The district court reversed a finding by the Board of repeated malpractice and affirmed a separate finding of gross malpractice.

Proceedings Below

Dr. Harriston Lee Bass, Jr. ("Dr. Bass") is a Board certified general surgeon. The Nevada State Board of Medical Examiners ("the Board") found Dr. Bass guilty of gross negligence in the care of a female patient ("Patient A") who died following laparoscopic surgical treatment for massive abdominal adhesions. See NRS 630.301(3). The Board also found Dr. Bass guilty of "repeated" malpractice in connection with his treatment of a male patient ("Patient B")

who died from complications following surgery to repair an inguinal hernia.[1] See NRS 630.301(4).

The Board revoked Dr. Bass' medical license, stayed the revocation and placed Dr. Bass on three years probation, subject to several conditions: (1) that he cease performance of laparoscopic surgeries; (2) that he perform all surgeries, except minor office procedures, at JCAHA-approved facilities with the assistance of a board-certified surgeon; (3) that he provide reports to the Board on all surgeries performed; (4) that he provide proof of completion of 120 hours of continuing medical education in surgery; and (5) that he complete the American College of Surgeons Surgical Education and Self-Assessment Program.

Dr. Bass petitioned the Board for a rehearing, which was denied. He then filed his initial petition for judicial review of the Board's findings with the district court, and applied for leave to present additional information and to correct and supplement the record before the Board. Thereafter, the district court remanded the proceedings to the Board for consideration of additional evidence.

After consideration of the additional evidence, the Board affirmed its earlier findings and conclusions determining that the additional evidence was immaterial, irrelevant, or redundant. Dr. Bass then filed the petition for judicial review that is the subject of this appeal.

On judicial review the district court affirmed the Board's findings of gross malpractice with regard to the female patient, Patient A. It reversed the Board's decision that repeated malpractice had been committed in

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[1]The Board dismissed a third and separate accusation against Dr. Bass brought pursuant to NRS 630.301(7).

connection with the treatment of the male patient, Patient B. The Board appeals, contending the district court erred in reversing its finding of repeated malpractice with regard to Patient B.[2] Dr. Bass cross-appeals, contending (1) that clear and convincing evidence does not support the respondent's finding of gross malpractice with regard to Patient A, and (2) the Board denied him due process in the administrative proceedings before it.[3]

DISCUSSION

Whether the findings of the Board were supported by clear and convincing evidence

1. Standard of review

NRS;' 233B.135(3)(e provides that a reviewing court may set aside a final decision of an administrative agency if the final decision is clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record. However, in medical license revocation proceedings, this court has conclued that, under NRS 630.352(1), the Board's factual findings and conclusions based thereon must be supported by clear and convincing evidence. See

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[2]The finding of "repeated" malpractice with regard to Patient B was based upon the finding with regard to Patient A. Dr. Bass' treatment of Patient B occurred approximately two years after his treatment of Patient A.

[3]The district court ordered proceedings with regard to Patient A remanded to the Board for a determination of "what sanction, if any, should be imposed." Ostensibly, this was done to allow the Board to reconsider the extent of discipline given the reversal of the findings as to Patient B. Dr. Bass argues that the immediate taking of an appeal by the Board from the adverse decision with regard to Patient B, was another example of the Board's "arbitrary and capricious" behavior. We reject this contention. The finding as to Patient B was a final order subject to appeal. See NRS 233B.150.

Minton v. Board of Medical Examiners, 110 Nev. 1060, 1078, 881 P.2d 1339, 1352 (1994). As such, NRS 640.352(1) supersedes that portion of the administrative procedure act subjecting factual findings to the "clearly erroneous in view of the reliable, probative and substantial evidence" standard. Minton, 110 Nev. at 1078, 881 P.2d at 1352.

> Further,
> where the burden on the prosecuting authority is to establish violations by clear and convincing evidence, this court will not engage in independent -- or de novo -- review. This court will instead review the record and decision with a degree of deference, seeking only to determine whether the evidence adduced at the hearing was sufficient to have convinced the deciding body that violations had been shown by clear and convincing evidence. Moreover, this court is prohibited from substituting its own judgment for that of the Board as to the weight of the evidence on a question of fact. Finally, it is the province of the Board to make credibility determinations and this court is not permitted to pass on the credibility of witnesses or to weigh their testimony.

Id. at 1079, 881 P.2d at 1352 (footnote omitted) (citations omitted).

Clear and convincing evidence must be satisfactory proof that is:

so strong and cogent as to satisfy the mind and conscience of a common man, and so to convince him that he would venture to act upon that conviction in matters of the highest concern and importance to his own interest. It need not possess such a degree of force as to be irresistible, but there must be evidence of tangible facts from which a legitimate inference . . . may be drawn.

In re Drakulich, 111 Nev. 1556, 1566, 908 P.2d 709, 715 (1995) (quoting Gruber v. Baker, 20 Nev. 453, 477, 23 P. 858, 865 (1890)).

NAC 630.251 defines the parameters for a Board finding of gross negligence, the test applicable to the charges regarding Patient A:

For the purposes of NRS 630.301, as that section existed before October 1, 1997, a physician shall be deemed to have committed gross malpractice if, before October 1, 1997, he has failed to exercise the required degree of care, skill or knowledge and such failure amounts to:

1. A conscious indifference to the consequences which may result from the malpractice; and

2. A disregard for and indifference to the safety and welfare of a patient.[4]

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[4]NRS 630.301 states, "The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure: . . . (4) Malpractice, which may be evidenced by claims settled against a practitioner."

Throughout these proceedings, the Board defined "gross malpractice" as "that lack of care which raises a presumption of conscious indifference to consequences, an entire disregard for and indifference to the safety and welfare of a patient."

The test with regard to the charges made in connection with Dr. Bass' care and treatment of Patient B comes from the statutory definition of the term "medical malpractice." NRS 41A.009 defines medical malpractice as the "failure of a physician . . . in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances." Throughout these proceedings, the Board defined "malpractice" as "the failure of a physician to apply that degree of skill and learning with ordinary and reasonable care in treating a patient; that is customarily applied in treating and caring for the sick or wounded similarly suffering."[5]

A. Patient A

Dr. Bass contents clear and convincing evidence does not support the Board's finding of gross malpractice with respect to his care and treatment of Patient A. In this, he posits a conspiracy theory; that is, other medical practitioners interfered with his treatment of the patient, subjected her to unnecessary additional surgery which caused her death; and then destroyed and/or altered medical records in an attempt to shift the blame to him. More particularly, Dr. Bass argues that:

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[5]We conclude that the Board's working definitions of "gross malpractice" and "malpractice" are consistent with the statutory definitions of those terms.

(1) The Board commenced its investigation based upon a letter from a physician that contained false accusations.

(2) Medical records documenting the treatment of Patient A were found during the initial hearing in the trunk of an automobile belonging to Dr. Marina Plon, one of the physicians who Dr. Bass contends committed malpractice.

(3) Reports documenting the initial examination of Patient A and preoperative findings were never made, or were removed from hospital records. This claim refers to the records of Dr. Golam Choudhury, another physician involved in Patient A's subsequent care.

(4) Dr. Choudhury's operative report was falsified.

(5) Pathology findings did not support Dr. Choudhury's operative report.

(6) Al records inconsistent with Dr. Choudhury's operative report, and evidence of individuals altering medical records, were removed from hospital records.

(7) The Board ignored all evidence presented that indicated that Dr. Bass acted in accordance with professional standards.

(8) The true cause of death was the placement of Patient A for CVP monitoring, which allowed acid to flow into Patient A's lung, causing aspiration pneumonia and death shortly thereafter.[6]

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[6]The Board points out that the insertion of the CVP line and the positioning of the patient could not have caused Patient A's death because a naso-gastric tube was in place at the time of the insertion that was hooked to a suction device that transfers all stomach contents to a bedside container.

By contrast, the Board contends that clear and convincing evidence presented at the hearing established that Dr. Bass committed gross malpractice with respect to his treatment of Patient A. The Board further argues that Dr. Bass failed to cite to any evidence in the record establishing a conspiracy to alter and/or destroy medical records in an effort to shift blame to him. We agree with the Board.

First, Dr. Bass fails to offer any evidence to support his conspiracy claim. His opening and reply briefs are devoid of adequate citations to the record that would confirm the alleged cover-up. We therefore turn to the considerable evidence considered by the Board with regard to Dr. Bass' treatment of Patient A.

At the hearing, expert and percipient witnesses testified and were cross-examined at length. Other professional opinions were admitted into the record via affidavit. Thus, comprehensive evidence was heard from both sides regarding the events leading to the demise of both patients.[7] With regard to Patient A, the Board made the following findings: (a) laparoscopic surgery for the sole purpose of lysis of adhesions from prior abdominal surgeries without evidence of abdominal obstruction was contraindicated in Patient A; (b) Dr. Bass performed the surgery in a negligent and careless manner; (c) Dr. Bass failed to exercise proper surgical judgment in continuing with the procedure when confronted with obvious

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[7]The original hearing prior to remand took some eighteen days and was held in scattered sessions over a period of two and one-half months. Approximately thirty-two witnesses testified , thirty of which were called by Dr. Bass. All but three of the witnesses testified disfavorably to Dr. Bass.

contraindications; (d) during surgery, Dr. Bass failed to recognize the extent and seriousness, and failed to repair an iatrogenic (physician caused) injury inflicted upon Patient A; and (e) after the initial surgery, Dr. Bass failed to adequately diagnose and treat the patient.

In sum, the Board concluded:

> Dr. Bass' conduct amounted to a total disregard for the safety and welfare of the patient. In addition to the negligent way in which the surgery was performed, Dr. Bass failed to recognize and treat a life-threatening perforation of the sigmoid colon, which was manifested by the presence of massive infection in the patient's right flank and abdominal wall and further evidenced by signs of septic shock and respiratory failure. Moreover, Dr. Bass failed to adequately communicate the dire condition of the patient at the time of the transfer. Based upon those factors, the Board unanimously concludes that Dr. Bass' care and treatment of Patient A constituted a lack of care to the point of conscious indifference to consequences, and an entire disregard for and indifference to the safety and welfare of the patient.

Dr. Juell, the primary witness called against Dr. Bass at the hearing, reviewed a videotape of the laparoscopic surgery and testified that Bass exhibited "a very poor technique which should have been abandoned in favor of an open operation at an earlier time. Dr.

Juell concluded that Dr. Bass' decision to continue with the laparoscopic surgery to relieve Patient A's adhesions was directly responsible for Patient A's post-operative complications, which were subsequently not treated appropriately by Dr. Bass, and ultimate death. Dr. Juell also testified that Patient A evinced signs of an infected abdomen, which Dr. Bass was unable to recognize and treat.

In his final report to the Board, Dr. Juell formulated the following conclusions and opinions:

> 1.. . . . [Patient A] was an unsuitable candidate for surgery for relief of pain due to intestinal adhesions.
>
> 2. Bass failed to exercise appropriate surgical judgment when confronted with obvious contraindications to proceeding with laparscopic enterolysis.[8] He clearly lacked the appropriate skill and experience but persisted in surgery thereby exposing [Patient A] to mortal danger and injury.
>
> 3. Bass recognized, but failed, to adequately repair iatrogenic injury at the time of the initial operation directly leading to the patient's clinical deterioration and her ultimate demise.
>
> 4. It is clear that the operative reports of Dr. Bass were inaccurate in that a-1 cm serosal laceration of the ileum was found by Dr.

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[8]Surgical therapy of intestinal adhesions.

Choudhury to be a 4 inch transmural laceration.[9]

5. There was circumstantial evidence to suggest that Dr. Bass recognized the potential for infection and bleeding when he wrote post operative order for a 10 day therapeutic course of antibiotics and subsequently for close monitoring of the patient's blood count in the early post operative period.

6. At the time of reoperation Dr. Bass failed to recognize a life threatening perforation of the sigmoid colon[10] and the presence of infection in the patient's right flank and abdominal wall.

7. Dr. Bass failed to recognize, or perhaps just admit, that the patient developed septic shock and respiratory failure following [her] second operation.

8. Finally, Dr. Bass failed to adequately communicate or appreciate the dire status of [Patient A] at the time of transfer of care to another physician.

It is my conclusion that Dr. Bass failed to adequately diagnose and treat, that his actions were well below the standard of care in this case. I believe that his persistence in his attempt at laprascopic enterolysis despite clear

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[9]Laceration across the wall of an organ or structure.
[10]Lower part of the descending colon.

> contraindications to proceeding constitutes an act of gross malpractice. Dr. Bass was clearly negligent in his failure to accurately diagnose, treat or convey his findings in [Patient A's] case.

Footnotes added.

Dr. Byron McGregor, Professor of Surgery at the University of Nevada School of Medicine, reviewed the medical records and concluded that Patient A suffered surgical complications which resulted in premature death. Dr. McGregor testified in favor of Dr. Bass that, while iatrogenic perforation of Patient A's colon was unquestionably a technical mistake, there was no evidence in the documents provided to him that proved medical malpractice on the part of Dr. Bass.

Dr. James Pitts, a board certified general surgeon, provided a letter to the Board giving his opinion that Dr. Bass committed malpractice (in opposition to "gross malpractice") in his treatment of Patient A. More particularly, Dr. Pitts criticized the use of laprascopic lysis of Patient A's abdominal adhesions and the failure to recognize bowel perforation that caused general peritonitis. (Dr. Bass noted the problem as a "serosal tear," Dr. Pitts pointing out that a serosal tear is only a partial thickness tear of the bowel.)

Dr. Golam Choudhury ("Choudhury") took over surgical care of Patient A from Dr. Bass upon Patient A's transfer to Desert Springs Hospital. In his affidavit to the Board, Dr. Choudhury concluded that Dr. Bass acted "way below" the acceptable and reasonable level and standard of care by a surgeon. He based this conclusion on Dr. Bass' (1) poor selection of

surgical procedure in deciding to divide Patient As adhesions via laparoscope rather than conducting a formal laparotomy; (2) poor laparoscopic technique; (3) failure to repair properly and explore Patient A's abdomen for other injuries to her bowel and hemorrhaging upon discovering a tear in the small bowel; (4) failure to repair a tear in the colon, the contents of which he left leaking into the periotoneal (abdominal) cavity, caused by his surgery; and (5) failure to communicate regarding his repair of the bowel laceration. Dr. Choudhury determined that "[a]ll of these errors resulted in overwhelming sepsis, pulmonary complications, and multiple organ failure leading to the death of [Patient A]."

Dr. Joel Davidson ("Davidson") reviewed Patient A's medical records. Included in his affidavit admitted into evidence at the hearing, was Dr. Davidson's observation that:

> [Patient A] was transferred to the Intensive Care Unit of Desert Springs Hospital on July 20, 1990. Dr. Bass' transfer notes state the patient did well up until 2:00 a.m. on July 20. This is simply untrue. She had hypotension on July 17 with hypovoleminia.[11] and ARDS . . . on July 19. She had a considerable narcotic requirement for pain. She had transfusions, hypoxemia[12] and was septic. And, further, a second surgery needed to be done before transfer. She truly did not do well.

(Footnotes added.)

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[11] Diminished blood volume.

[12] Insufficient oxygenation of the blood.

Dr. Lawrence Gardner ("Gardner") examined Patient A's medical records and provided an affidavit summarizing his review and analysis of Dr. Bass' conduct, and concluding that Dr. Bass conducted himself below the standard of care of a reasonably competent surgeon and physician. Dr. Gardner offered the following clinical opinion:

> On July 18, 1990, the patient was returned to the operating room because of the abdominal wall hemorrhage. The abdomen was explored through a midline incision and adhesions from the pelvis to the upper abdomen were lysed. An injury in the bowel (cecum) was adequately repaired. An injury to the pelvic colon was missed and left to drain freely into the peritoneal cavity. The hemorrhage or sepsis in the anterior abdominal wall was not explored or debrided.[13]
>
> As a consequence of the open colon, the patient developed peritonitis and became more septic and toxic. From July 18 to July 20, 1990, she developed increasing septic shock and multiple organ failure. The abdominal wall developed synergistic gangrene either as a progression of the process initiated by the surgery on July 17, or because of secondary contamination to the hemorrhagic abdominal wall from bacteria

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[13]Removed. (Debridement = removal of foreign material and dead or damaged tissue.)

released by the open intra-abdominal colon.

The peritoneal abscesses and abdominal wall necrosis were not diagnosed and therefore inappropriately treated, i.e., neither explored, drained, debrided, nor repaired. As a result, the patient's septic condition deteriorated to the point where the organ damage became irreversible. Despite proper treatment at Desert Springs Hospital, the patient died.

Dr. John Wilson reviewed Patient A's medical records and provided an affidavit admitted into evidence that, contrary to the above reflected favorably on Dr. Bass:

> [The Board] and their expert witnesses have asserted that [Patient A] was a poor candidate for laparoscopic lysis of adhesions. The decision as to whether or not to attempt the lysis of adhesions laparscopically is a judgment call that is to be based upon the particular surgeon's level of experience with lapaoscopic procedures. There is no indication in the affidavits of [the Board's] expert witnesses that they are aware of the level of expertise and experience that Dr. Bass has in performing laparoscopic procedures. Merely because [the Board's] expert witnesses would not have felt comfortable performing the procedure laparscopically does not make it per se below the standard of

> care for a surgeon that is experienced in laparoscopic surgery to attempt the subject operation. . . .
>
> Delayed bowel injuries can result from traumatic perforations that the surgeon does not recognize at the time of the procedure . . . , or from thermal damage from any source. . . .With traumatic perforation, symptoms generally occur within 24 to 48 hours, although their occurrence up to eleven days later has been reported. Bowel perforation following thermal injury may be seen four to ten days after the procedure. . . .The probability that the perforation occurred from a delayed ischemic blowout or delayed bowel injury is more likely than the conclusion posited by Dr. Choudhury that the injury was caused by Dr. Bass . . . .
>
> [I]t is medically probable that the laceration of the colon that had not been repaired and was leaking colon contents was caused by a delayed ischemic blowout occurring after the laparoscopic lysis of adhesions and laparotomy. . . .

This court has not yet been called upon to establish a threshold test for determinations of gross malpractice in this context. Federal and state court holdings only provide examples, such as performing an abortion when the length of the pregnancy was underestimated by four months,

practicing under the influence of drugs or alcohol, abandoning a pregnant female patient with a prolapsed umbilical cord, improper placement of emergency patients during transport, sexual abuse, deliberate falsification of patient records, etc. See Major v. Dept. of Pro. Regulation, 531 So. 2d 411, 414 (Fla. 1988); Ticktin v. Dept. of Professional Reg., 532 So. 2d 47, 49 (Fla. 1988); Kauffman v. Dept. of Commerce, 746 P.2d 103, 106 (Mont. 1987); In Re Jascalevich License Revocation, 442 A.2d 635, 644 (N.J. 1982); In Re Polk License Revocation, 449 A.2d 7, 19 (N.J. 1982). Thus, because prior case authority provides only episodic examples of gross malpractice, under the standard of deferenced mandated in minton, a court on judicial review may only reverse in the event the record fails to demonstrate "sufficient" evidence in support of the Board's findings. See Minton v. Board of Medical Examers, 110 Nev. 1060, 1079, 881 P.2d 1339, 1352 (1994).

Although only one expert expressly found that gross malpractice has been committed, and although there was some disagreement concerning Dr. Bass' treatment of Patient A, the Board was entitled to resolve the questions of credibility and probative value of evidence elicited in support of and against the claims of gross negligence. We conclude that the opinions given against Dr. Bass were specific and competent from an evidentiary standpoint. While Drs. McGregor and Wilson were certainly competent experts, the Board could reasonably have concluded that their offerings were speculative and general.

We therefore conclude that, under the deference that must be given to the findings of

the Board under Minton, sufficeint evidence was submitted to the Board that supports its findings that Bass committed gross negligence in his care and treatment of Patient A. Under Minton, although there was conflicting evidence, the Board is entitled to our deference to its determinations on credibility and weight of the evidence submitted to it.

B. Patient B

The primary complaint with regard to patient B was not that the original hernia reduction was performed improperly, but rather, that Dr. Bass failed to timely and properly recognize a post-surgical complication, to wit: a cecal volvulus.

Dr. Bass contends clear and convincing evidence does not exist to support the Board's finding that he committed malpractice with respect to his care and treatment of Patient B. Dr. Bass argues that other medical practitioners prevented him from proceeding with scheduled surgery for Patient B following his post-surgical re-evaluation, thereby causing a five-hour delay in the commencement of said surgery and, ultimately, the patient's death. More particularly, Dr. Bass contends that he appreciated or observed the post-surgical turn for the worse at Women's hospital, that he attempted to transfer the patient to University Medical Center {"UMC"}, that the admission to the second facility was obstructed by that hospital's administration, that the patient was taken from Dr. Bass' care and treated by Dr. Hugh Follmer, M.D., and that a delay in surgery at UMC was the cause of Patient B's death. Dr. Bass also argues that medical records reflecting his scheduled surgery for Patient B were

removed from hospital records as part of a cover-up.

By contrast, the Board contends that clear and convincing evidence exists to support the Board's finding that Dr. Bass committed malpractice with respect to his treatment of Patient B, and the district court erred in reversing that finding. The Board further contends that Dr. Bass offers no evidence regarding the destruction and/or alteration of medical records.

As is the case with Patient A, Dr. Bass has failed to provide this court with any verifiable evidence that any individual(s) destroyed and/or altered medical records. Further, the deficiencies of which he now complains were either cured or brought to the Board's attention on remand. Therefore, his allegations of a cover-up with respect to Patient B likewise lack merit.

Dr. Juell also provided evidence against Dr. Bass with regard to the care and treatment of Patient B:

> It is my opinion that Dr. Bass failed to properly diagnose and treat [Patient B] in a timely fashion resulting in significant harm to the patient. . . .
>
> . . . .
>
> A patient presenting with abdominal pain, distention, tenderness, marked leukocytosis[14] and radiographic evidence of bowel obstruction with

[14]Elevation of leukocytes ("white blood corpuscles") in the blood beyond 10,00 per cu. mm, is generally caused by infection.

pneumoperitoneum[15] should be more completely evaluated at the time of the initial presentation. Mere observation and empiric antibiotics and IV fluids does not constitute proper care for this patient. Although indications for operative intervention may have been present such a patient would be better served to be evaluated with further radiologic study. Had Dr. Bass requested a gastrografin enema, the diagnosis of cecal volvulus could have been established at the time of the patient's admission. Unfortunately this was not the case.

. . . .

I believe that the patient's sepsis and complications resulting from his cecal volvulus were frankly preventable, if [Patient B] had received an appropriate evaluation at the time of his readmission to the hospital. It is of deep concern to me that a Board Certified General Surgeon could see a patient with evolving peritonitis and intestinal ischemia for a 2 day period on multiple occasions and fail to appreciate the serious nature of the patient's illness and intervene appropriately. Dr. Bass' failure to make the diagnosis directly resulted in harm to the patient and clearly constitute malpractice.

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[15] Condition in which air or gas is collected in the abdominal cavity.

(Footnote added.)

Dorothy Miller, a registered nurse at Women's Hospital testified that her examination of Patient B on the morning after he had been admitted revealed a surgical abdomen, a diagnosis with which one-half dozen other nurses on staff apparently agreed.

Dr. Barry Fisher, a surgeon with privileges at Women's Hospital concluded that:

> You have a case here where Dr. Bass did a good [hernia] operation, and it just fortuitously happened that the patient developed a ceco volvulus. God did it. He didn't do it. God did it. The problem was that Dr. Bass didn't tumble to it. . . . I'm saying that it was not reasonable medical judgment. I couldn't live with myself if I hadn't operated on this patient sooner in light of what happened. I couldn't go to sleep at night.

Dr. James Tate, Chief of Surgery at University Medical Center, testified in favor of Dr. Bass:

> One, cecum volvulus is relatively rare. Two , very seldom that you make a diagnosis preooperatively. You usually stumble upon it, because you thought it was something else, and it turned out to be something different. And much of the times you go in, the bowel is gangrenous, because it's a very difficult diagnosis to make.
>
> We have the patients at both UMC and Desert Springs when we

have presented the x-rays to the radiologist after operating on the patient, and he knows that it's ceco volvulus. And they have looked at it and said I would not have called that ceco volvulus in looking at the x-rays. They had also had what they called a ceco volvulus, and it wasn't anything that was close to that. Like, I say, it's a very difficult diagnosis to make.

. . . .

The strangulation took place a relatively short period of time before we went to surgery at UMC. If it would have been any longer, you would have a perforation.

Notwithstanding Dr. Tate's testimony, the Board found the following with regard to the care and treatment of Patient B:

Dr. Bass failed to appropriately evaluate the patient postoperatively. He failed to appreciate the serious nature of the patient's condition and failed to make a diagnosis and intervene appropriately. A patient with abdominal pain, distention, tenderness, marked leukocytoses and radiographic evidence of bowel obstruction with pneumoperiotoneum should have been more completely evaluated. Mere observation and emperic antibiotics and IV fluids failed to

> provide adequate care for this patient Dr. Bass' failure to conduct an appropriate evaluation at the time of the patient's readmission to the hospital constituted malpractice. . . .[A] board-certified surgeon should have recognized a patient with evolving periotonitis and intestinal ischemia and reacted immediately to the serious nature of the patient's illness. The Board finds that Dr. Bass' conduct constituted a failure to apply that degree of skill and learning with ordinary and reasonable care in treating a patient that is customarily applied in treating and caring for the sick or wounded similarly suffering, and therefore constitutes malpractice.

The district court reversed the Board, concluding that "there is not substantial evidence in the record to justify the determination of the Board." "Dr. Bass wanted to operate on Patient B and was prevented from doing so, which action could not constitute malpractice since the delay in the operation was the cause of the injury to Patient B."[16]

In reversing the Board, the district court relied on an affidavit from Dr. Craig Voss, the pathologist who examined the damaged tissue taken from Patient B. Dr. Voss indicated that "the tissue is consistent with a volvulous that

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[16]As noted, Dr. Bass unsuccessfully attempted to transfer Patient B to another facility in order to operate. Dr. Hugh Follmer, at the request of the family, eventually operated on Patient B some five hours after transfer was ultimately effected.

occurred approximately six hours before the recovery of such tissue. . . .

[T]hat it is reasonable from the examination of the condition of the tissue that it was the result of a sudden, complete volvulous." Apparently, this meant that Patient B's bowel had been twisted for no more than six hours prior to surgery, and the district court concluded that the five-hour delay in the surgery, through no fault of Dr. Bass, was the proximate cause of Patient B's death.

When the district court mentioned Dr. Voss' affidavit during argument, the Board responded by referencing the testimony of Dr. Fisher, who testified that Patient B was sick enough to undergo surgery some two or three days prior to the day the surgery was actually performed. In fact, it should be noted that the Board had expressly determined previously on remand that "the pathology did not develop due to a five hour delay but had developed much sooner," a fact that the district court ostensibly did not consider. Referencing the testimony and report of Dr. Juell, the Board also argued that Dr. Bass' malpractice stemmed from the fact that he was unable to diagnose evolving peritonitis and intestinal ischemia over a two-day period prior to the actual surgery, which directly harmed Patient B. In effect, the Board concluded that, as Drs. Juell and Fisher testified, Dr. Bass should have operated on Patient B some two or three days earlier.

To summarize, Drs.. Juell and Fisher found the existence of malpractice while Dr. Tate found to the contrary. Based upon credible expert testimony and the medical record, the Board expressly concluded that the five-hour delay in surgery was of no consequence.

We likewise conclude that, under the deference that must be given to the Board's findings under Minton, sufficient evidence was submitted supporting its findings that Bass committed repeated malpractice in his care of Patient B. Again, although there was conflicting expert evidence, the Board's determinations, credibility and weight of the evidence submitted to it must be accorded deference by a reviewing court. Because the district court failed to follow this standard of review, its order on judicial review overturning the Board's decision as to Patient B must be reversed.[17]

Whether the Board deprived Dr. Bass of due process.

1. Standard of review

> Generally, the right to practice medicine is a property right protected by the due process clauses of the United States and Nevada Constitutions, and a license to practice medicine may not be arbitrarily abridged or revoked. As a result, due process protections apply in administrative hearings to revoke a medical license. . . .
>
> ,However, the legal process due in an administrative forum is

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[17]Dr. Bass' counsel at oral argument on this appeal contented that Dr. Bass himself saw the problem develop on an emergent basis at Women's Hospital and that he then sought transfer to the second facility. Thus, he argues that the delay at the second facility was the cause of the patient's ultimate demise. This, however, was in direct conflict with the testimony of Dr. Fisher and the records, which indicate that it was only after Dr. Bass' interaction with Dr. Fisher that Dr. Bass fully appreciated the gravity of the patient's condition.

> flexible and calls for such procedural protections as the particular situations demands." To determine whether a give procedure appropriately safeguards an individual's due process guarantees, a reviewing court must weigh: (1) the private interest affected by the official action; (2) the risk of an erroneous deprivation of that private interest through the procedures used and the probable value, if any, of additional or substitute procedural safeguards; and (3) the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.

Minton, 110 Nev. at 1082, 881 P.2d at 1354 (quoting Burleigh v. State Bar of Nevada, 98 Nev. 140, 145, 643 P.2d 1201, 1204 (1982) (citations omitted)).

Dr. Bass contends the Board denied him due process for the following reasons:

(1) He was unable to conduct any pre-hearing discovery;

(2) Incomplete medical records were provided to him and submitted to the Board even though the custodian of records certified them as complete;

(3) Hospital personnel destroyed relevant medical records:

(4) The Board relied on Dr. Choudhury's affidavit, which Dr. Bass alleges was falsified, rather than calling Dr. Choudhury to testify as a witness;

(5) The Board quashed subpoenas unless Dr. Bass made offers of proof once it became clear that Dr. Bass was about to reach the truth.

(6) Dr. Bass was not allowed to participate or be present during the adjudication of the charges against him; and

(7) The Board failed to have the medical records gathered and evaluated by "qualified assurance personnel," failed to gather peer review items, and failed to investigate "record defalcations."

By contrast, the Board contends due process was satisfied by th following reasons:

(1) Dr. Bass had an opportunity at the hearing to call witnesses, cross-examine the Board's experts, introduce and rebut evidence, and make a closing argument;

(2) Dr. Bass has not identified any exculpatory evidence that has been denied him;

(3) Neither federal nor Nevada statutory law requires pre-hearing discovery, and there is no constitutional right to discovery in administrative hearings; and

(4) There exists no statutory or due process right to participate in the Board's adjudication of a case, and the Board's deliberations are not subject to the Nevada open meeting law. See NRS 241.010(1).

We conclude that the procedures employed by the Board did not erroneously deprive Dr. Bass of his due process rights, and that additional or substitute procedural safeguards would have been of no value given the length and comprehensive nature of the proceedings. Indeed, Dr. Bass received a copy of all medical records and expert reports prior to the hearing, presented evidence, and examined/cross-examined some thirty-two

witnesses. Further, many months later, Dr. Bass was given the opportunity to cure any deficiencies perceived in the record of the first hearing.

A. Pre-hearing discovery

NRS 233B.121 establishes in relevant part that all parties in contested administrative agency cases must be afforded an opportunity for a hearing after reasonable notice and an opportunity to respond and present evidence and argument on all issues. NRS 233B.123(4) establishes that, during the adjudication of contested cases, "[e]ach party may call and examine witnesses, introduce exhibits, cross-examine opposing witnesses on any matter relevant to the issues . . . impeach any witness. . . . and rebut the evidence against him." No Nevada statutory provision provides for discovery in administrative proceedings. Dr. Bass has not demonstrated anything to the contrary.

Although no Nevada cases have addressed whether failure to provide an opportunity for discovery in an administrative proceeding violates due process, other jurisdictions have concluded that the failure to provide an opportunity to obtain discovery does not render an administrative hearing process unconstitutional. See Matter of Tobin,. 628 N.E.2d 1268, 1271 (Mass. 1994) (discovery is not a constitutional right, rather it stems from statutes or court rules); Ubiotica Corp. v. FDA, 427 F.2d 376, 381 (6th Cir. 1970). In Petitioner v. Dept. of Health Services, 638 A.2d 6, 20 (Conn. 1994), the court stated:

> It is well-settled that parties to judicial or quasi-judicial proceedings are not entitled to pre-trial discovery

> as a matter of constitutional right . . . . Pre-trial discovery may be expressly authorized by statute, but, absent an express provision, the extent to which a party to an administrative proceedings is entitled to discovery is determined by the rules of the particular agency.

Id. (quoting Pet v. Dept. of Health Services 542 A.2d 672, 677 (Conn. 1988)). Even the seminal due process opinion in this area. Goldberg v. Kelly, 397 U.S. 254 (1970), did not require discovery in this context.[18]

B. Allegedly incomplete and destroyed medical records

Dr. Bass argues that he and the Board received incomplete copies of all medical records despite certification that they were complete. Dr. Bass points to the fact that medical records were discovered in the trunk of Dr. Plon's automobile during the initial hearing.

On remand, the Board reviewed several pieces of additional evidence per the district court's order, including the records discovered in the trunk of Dr. Plon's automobile. In its order affirming its previous findings, the Board

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[18]In Goldberg, the United States Supreme Court held that a pre-termination hearing regarding welfare benefits must include the following: (1) 'timely and adequate notice detailing the reasons for a proposed termination"; (2) an effective opportunity [for the recipient] to defend by confronting any adverse witnesses and by presenting his own arguments and evidence orally"; (3) retained counsel, if desired; (4) an "impartial decision-maker"; (5) a decision resting "solely on the legal rules and evidence adduced at the hearing"; and (6) a statement of reasons for the decision and the evidence relied on. Id. at 266-71. We see no violation of these safeguards.

concluded that the records from Dr. Plon's automobile were, with the exception of an echocardiogram that could not have come from Women's hospital, duplicates.[19] There has been no offering by Dr. Bass that demonstrates the Board relied upon an altered, secret or incomplete record. In this connection, we note that Dr. Bass has attempted to supplement the record after the commencement of briefing. The supplement and the briefs made no attempt to direct this court to the substantive significant of the defalcations he claims have been perpetrated upon him. See NRAP 28 and 30(b). Further, Dr. Bass does not demonstrate that the alleged deficiencies somehow changed the documentation of his treatment of either Patient A or B at Women's Hospital. Again, all of the problems he addresses were either considered or could have been considered at the second hearing on remand.

Dr. Bass also contends that critical record were destroyed. Dr. Bass provides no evidence to support this contention. Rather, a comprehensive review of the record supports the Board's contention that records relied on by

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[19]The record suggests that the echocardiogram, which Dr. Bass now contends on appeal was evidence that one of the problems encountered after Patient A was removed from his care was a "heart attack," came from UMC, not Women's Hospital where Dr. Bass treated Patient B. Thus, the echocardiogram we most probably obtained independently by Dr. Plon, she having only been provided records by the Board from Women's hospital. In any event, the Board was provided the echocardiogram during the hearings on remand. The Board determines that it was without significance to the propriety of treatment rendered by Dr. Bass prior to the transfer of Patient B to UMC.

Board members that were destroyed were duplicates.

C. Dr. Choudhury's affidavit

The Board admitted an affidavit from Dr. Choudhury without his live testimony. We agree with the principle that "[I]n almost every setting where important decisions turn on questions of fact, due process requires an opportunity to confront and cross-examine adverse witnesses." Goldberg, 397 U.S. at 269. However, there exists sufficient evidence apart from the affidavit from which the Board could find gross malpractice with respect to Dr. Bass' treatment of Patient A. Cf., Laman v. Nevada R.E. Adv. Commission 95 Nev. 50, 60, 589 P.2d 166, 172 (1979_ (holding that in context of real estate license revocation, Real Estate Advisory Commission did not err in revoking appellant's license because it had sufficient evidence in its possession to justify revocation apart from an affidavit from adverse witness who did not testify). We conclude that the use of affidavits did not deny Dr. Bass of his rights to due process of law.[20]

D. Quashing of subpoenas

Dr. Bass registers his protest to the Board's quashing of subpoenas of Dr. Voss, Dr. Mulkey and three nurses from Women's Hospital. No offer of proof has ever been made at any level as to how testimony from these witnesses would have significantly affected the

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[20]The circumstances surrounding the failure to call Dr. Choudhury or use Dr. Choudhury's deposition from separate proceedings are confusing at best. It appears that a subpoena for Dr. Choudhury to testify at either his deposition or the hearing before the Board was quashed because Dr. Bass' counsel was in a conflict of interest, having represent Dr. Choudhury in other proceedings.

outcome. No indication that attempts to interview these witnesses appears of record. That witnesses have some prior contact with the Board does not alter the outcome. There is no indication that Dr. Bass was prevented from presenting his case that no malpractice of any kind has been committed by him and that the patients died as a result of outside interference. Certainly, over the course of the hearing, numerous subpoenas were issued and some thirty witnesses were brought into the hearing to testify.

Dr. Bass' protest that these subpoenas were quashed just at the point when Dr. Bass was getting at the truth remains unsubstantiated. Further, Dr. Bass was allowed on remand to introduce additional evidence, including evidence from Dr. Voss, and including all of the records in Dr. Plon's possession. Finally, on the subsequent remand to the Board, Dr. Bass could have attempted to substantiate the need for the few subpoenas he was refused prior to the close of proceedings in the first hearing before the Board. He either elected or failed to do so.

E. Other issues

Dr. Bass also argues, without specifics, that the records should have been gathered by quality assurance personnel, and that the Board should have gathered "peer review materials which contained important medical evidence and would have been the most efficient way to evaluate the care of these patients and evaluate the care received by all medical providers involved--not just Dr. Bass." No support or specifics are provided. Such being the case, we will not, at this level, review these allegations.

Dr. Bass also claims entitlement to participation in the Board's final adjudicatory process. Again, no support for this was offered and none exists. NRS 630.336(1) provides that deliberations conducted or votes taken by the Board are not subject to NRS 241.020, which provides that all meetings of public bodies must be open to the public Dr. Bass was not precluded from input into that process. This is clearly established by the fact that the hearings went on for many days and that Dr. Bass was able to present extensive evidence. Dr. Bass also had the advantage most litigant's lack. He was an expert himself who ostensibly could guide his own consultants through the procedural maze he contends enveloped him.

Conclusion

Under the standard of deference required under Minton, we affirm the district court's refusal to grant Dr. Bass relief with regard to the Board's findings with regard to Patient A. Similarly, we reverse the district court's ruling granting relief on judicial review of the Board's findings in connection with Patient B.

It is so ORDERED.[21]

/s/_____,C.J.
Rose

/s/_____J.
Young

/s/_____J.
Maupin

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[21]The Honorable Myron E. Leavitt, Justice, voluntarily recused himself from participate in the decision of this appeal..

/s/ _____ J.
Shearing

/s/ _____ J.
Agosti

_____ J.
Becker

cc: Hon. James C. Mahan, District Judge
Attorney General
R. Paul Sorenson
Michael V. Stuhff
Clark County Clerk

IN THE SUPREME COURT OF THE STATE OF NEVADA
Filed September 14, 1992
Case No. 23567

HARRISTON LEE BASS, JR., M.D., Petitioner, vs. THE EIGHTH JUDICIAL DISTRICT COURT OF THE STATE OF NEVADA, IN AND FOR THE COUNTY OF CLARK, AND THE HONORABLE JACK LEHMAN, DISTRICT JUDGE, Respondent, and BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA, THEODORE JACOBS, M.D.; EVA G. SIMMONS; THOMAS J. SCULLY, M.D.; DELMAR E. SNIDER, M.D.; IKRAN U. KHAN, M.D.; M)RONALD AVERY, JR., M.D.; LEO A. WILNER; BOARD MEMBERS OF THE NEVADA STATE BOARD OF MEDICAL EXAMINERS, AND RICHARD LEGARZA, HEARINGS OFFICER FOR THE NEVADA STATE BOARD OF MEDICAL EXAMINERS) Real Parties in Interest.

ORDER DENYING PETITION FOR WRIT OF PROHIBITION OR MANDAMUS

We have considered the petition on file herein, and we are not satisfied that this court's intervention by way of extraordinary writ is warranted at this time. Accordingly, we deny the petition. See NRAP 21(b).

It is so ORDERED.[22]

/s/ Mowbray ,C.J.

/s/ Rose , J.

/s/ Steffen , J.

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[22]In light of this order, we deny petitioner's ex parte application for order granting stay of proceedings of the State Board of Medical Examiners

BEFORE THE NEVADA STATE BOARD OF MEDICAL EXAMINERS
Filed December 29, 1993
Case No. 9455

In the Matter of the Complaint against)
HARRISTON LEE BASS, JR., M.D.,)
Respondent)

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

The Board, having carefully considered the transcript of the hearing, the exhibits, the testimony presented at the hearing and the arguments of counsel, makes the following Findings of Fact, Conclusions of Law, and Order.

The Board of Medical Examiners ("Board"), comprised of the following members: Theodore Jacobs, M.D.; Kathleen Ebner; Eva G. Simmons; Susan S. Buchwald, M.D.; Rex T. Baggett, M.D.; and Dipak K. Desai, M.D., adjudicated the above-captioned matter on December 2, 1993, at the Magnolia Room, Building 2, Holiday Inn, 325 East Flamingo, Las Vegas, Nevada. Members of the Investigative Committee were excused from the proceeding and took no part in the adjudication of the matter.

The hearing was conducted before a hearing officer on the following dates: July 6-9; September 7-10, 13-17; 20-24. Larry Lessly, Esq., appeared as prosecutor for the Nevada State Board of Medical Examiners. Page Underwood, Deputy Attorney General, appeared as counsel for the Board of Medical Examiners. Harriston Lee Bass, Jr., M.D., was present and represented by R. Paul Sorenson, Esq., of Las Vegas and Benjamin Spaulding, Jr., Esq., of Atlanta, Georgia.

STATEMENT OF THE CASE

A complaint was filed on June 5, 1992, alleging a violation of NRS 630.301(3). NRS 630.301(3) provides that the Board of Medical Examiners of the State of Nevada may initiate disciplinary proceedings against a physician on the grounds of gross or repeated malpractice. The one-count complaint alleged gross malpractice; specifically, that Dr. Bass failed to provide medical care to the point of conscious indifference to the consequences, and an entire disregard for and indifference to the safety and welfare of Patient A.

On November 19, 1992, an amended complaint was filed alleging two additional counts. Count Two contained allegations of a second violation of NRS 630.301(3); specifically, that Dr. Bass committed malpractice in his treatment of Patient B and that combined with the gross malpractice in treating Patient A, constituted repeated malpractice. A third count alleged that Respondent's care and treatment of Patients A and B constituted continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field, specifically general surgery, a violation of NRS 630.306(7).

An answer was filed denying each and every allegation contained in the complaint.

Notice of the hearing was filed on April 28, 1993, setting the matter for hearing commencing on July 6, 1993.

FINDINGS OF FACT

1. Patient A was admitted to Women's Hospital Out-Patient Department on 7-17-90. Medical records from Women's Hospital and the

video tape of the surgical operation showed that Dr. Bass performed laparoscopic surgery on Patient A for the purpose of lysis of adhesions to alleviate pain.

2. The Board finds, based upon the medical knowledge of the Board members and the expert testimony of the board-certified surgeons who have testified, including Dr. Juell who testified at the request of the Board and Drs. Davidson and Gardner who testified at the request of the Respondent, that surgery for the sole purpose of lysis of adhesion without evidence of abdominal obstruction, particularly in 1990 when laparoscopic surgery was a relatively new form of medical technology, was contraindicated in this patient. While the Board finds that the decision to undergo the surgery was not by itself gross negligence, it contributed to the Board's finding that the care given to this patient constituted gross malpractice when compounded by the factors outlined below.

3. The Board finds that the surgery was performed in a negligent and careless manner. Three attempts were necessary in order to obtain an unobstructed area into the abdominal cavity for the laparoscope. An inspection of the abdominal cavity revealed extensive adhesions of the omentum and small bowel which were connected to the anterior abdominal wall. From the video tape, it was clear that the massive extent of adhesions hindered careful surgical dissection. However, instead of ending the surgery laparoscopically and proceeding with an open surgery (laparotomy), which could have created better surgical conditions, Dr. Bass persisted using the laparoscope for three hours attempting to lyse the massive adhesions.

4. The Board finds, relying upon the Board's medical expertise, the video tape of the operation and the expert testimony of the board-certified surgeons Drs. Juell, Davidson and Gardner, that Dr. Bass failed to exercise appropriate surgical judgment by continuing with the surgery laparoscopically when confronted with the obvious contraindications. The Board finds that Dr. Bass' conduct constitutes a departure from the applicable standard of care for a board-certified surgeon.

5. The Board further finds that during the course of surgery, Dr. Bass failed to recognize the extent and seriousness of an iatrogenic injury and failed to adequately repair it at the time of the operation. Prior to the completion of the surgery, Dr. Bass reported a 1 cm. serosal (non-transmural) tear of ileum. In his operative notes, he stated that it was repaired through a 2 cm. right lower quadrant abdominal incision. However, a subsequent surgery performed by another surgeon revealed that in fact the laceration was not a 1 cm. serosal tear but rather a four-inch transmural laceration which had not been completely repaired and was leaking toxic bowel contents.

6. The Board finds that after the initial surgery, Dr. Bass failed to adequately diagnosis and treat Patient A. The patient presented with persistent complaints of pain and nausea. The nursing staff noted the appearance of large area of ecchymosis (bruising) in the right lower abdomen and flank about 10 hours after surgery. By the early morning rounds, Dr. Bass' notes indicated that the patient's hemacrit had dropped significantly. Dr. Bass' stated concern was that the patient had an expanding hematoma of the abdominal wall and he

scheduled the patient for an exploratory surgery. On 7-18-90, Dr. Bass performed a laparotomy, an open, non-laparoscopic surgery. He found no evidence of significant hemorrhage and found "what bleeding had occurred in the subcutaneous tissue appeared to be more prominent that it actually was." During entry into the abdomen, he reported a second serosal tear of the bowel which he again reported as being repaired.

After the second surgery, the patient developed hypoxia and respiratory insufficiency necessitating Dr. Bass to obtain a consultation with a cardiologist, Dr. Plon. The patient continued to complain of severe abdominal pain and developed increasing confusion. She had progressive hemodynamic instability manifested by tachycardia, hypotension and oliguria, a fever to 103 degrees, metabolic acidosis and leukocytosis progressing to leukopenia. On July 20, 1990, the patient required intubation and Dr. Plon recommended a transfer to Desert Springs. Dr. Bass was leaving town and he transferred the care of Patient A to Dr. Choudhury. Dr. Bass represented the patient to Dr. Choudhury as having congestive heart failure with pulmonary edema and pneumonia leading to respiratory failure. However, Dr. Bass reported that her abdomen was "stable." When Dr. Choudhury examined the patient at Desert Springs, he immediately diagnosed an acute surgical abdomen with evidence of sepsis and adult respiratory distress syndrome. This diagnosis was corroborated by several consulting physicians, Dr. Tawney, a pulmonologist, and Dr. Speck, an infectious disease specialist. Additionally, the CAT scan revealed the presence of subcutaneous emphysema of the right flank.

Upon operation, the patient was found to have an unrepaired laceration of sigmoid colon with accompanying peritonitis and abscess formation. Exploration of the abdominal wall confirmed the presence of synergistic gangrene or necrotizing fascitis. The patient expired on August 19,1990.

7. The Board finds based upon the totality of facts as outlined above that Dr. Bass' conduct amounted to a total disregard for the safety and welfare of the patient. In addition to the negligent way in which the surgery was performed, Dr. Bass failed to recognize and treat a life-threatening perforation of the sigmoid colon, which was manifested by the presence of massive infection in the patient's right flank and abdominal wall and further evidenced by signs of septic shock and respiratory failure. Moreover, Dr. Bass failed to adequately communicate the dire condition of the patient at the time of the transfer. Based upon these factors, the Board unanimously concludes that Dr. Bass' care and treatment of Patient A constituted a lack of care to the point of conscious indifference to consequences, and an entire disregard for and indifference to the safety and welfare of the patient.

8. On August 22, 1992, Dr. Bass performed an operative repair of an epigastric ventral hernia on Patient B. The patient was discharged and followed on an out-patient basis. By the second post operative day, the patient reported increasing abdominal distension and pain, nausea, vomiting and constipation. On August 24, 1992, the patient was seen by Dr. Bass, and Dr. Bass concluded that the patient was constipated and he treated him with anti-emetics, a liquid diet and cathartics. The patient's condition worsened and on 8-25-92,

his family took him to Las Vegas Medical Center. An abdominal x-ray was taken. Because of his condition, dehydrated with evidence of abdominal ileus, he was transported by ambulance to Women's Hospital. At Women's Hospital, Dr. Bass reviewed the x-rays and concluded that the patient had obstructing stool in the colon with the possibility of acute diverticulitis. The nursing notes reflected that the abdomen was distended and there were no bowel sounds. Exhibit 17-2, the x-rays taken at Las Vegas Medical Center revealed multiple dilated loops of the small bowel associated with air-fluid levels on upright examination. There were one or two bubbles of air in the rectum, most likely resulting from rectal examination and a paucity of air in the descending colon.

9. The patient's condition continued to deteriorate. Dr. Bass sought a second opinion only after pressure was exerted by the hospital administrators. On August 26, 1992, Dr. Bass contacted Dr. Barry Fisher, a board-certified surgeon. Dr. Bass advised Dr. Fisher that there was no emergency and told Dr. Fisher that seeing the patient the following morning would be acceptable. The following morning, immediately upon examining the patient, Dr. Fisher found the patient to be in extremis with massive abdominal distention, absent bowel sounds and diffuse rebound tenderness. Dr. Fisher immediately made the diagnosis of an acute surgical abdomen with a probable perforated viscus or obstruction and imminent sepsis and he recommended surgery immediately. The patient was transported to University Medical Center where he was seen by Dr. Follmer, who also examined the patient and also immediately recognized the need for

emergency surgery. During the surgery, Dr. Follmer found a volvulus of right colon and cecum with a dead bowel and established peritonitis. This patient also subsequently expired in the hospital.

10. The Board finds that Dr. Bass failed to appropriately evaluate the patient postoperatively. He failed to appreciate the serious nature of the patient's condition and failed to make a diagnosis and intervene appropriately. A patient with abdominal pain, distention, tenderness, marked leukocytosis and radiographic evidence of bowel obstruction with pneumoperitoneum should have been more completely evaluated. Mere observation and empiric antibiotics and IV fluids failed to provide adequate care for this patient. Dr. Bass' failure to conduct an appropriate evaluation at the time of the patient's readmission to the hospital constituted malpractice. The Board finds that a board-certified surgeon should have recognized a patient with evolving peritonitis and intestinal ischemia and reacted immediately to the serious nature of the patient's illness. The Board finds that Dr. Bass' conduct constituted a failure to apply that degree of skill and learning with ordinary and reasonable care in treating a patient that is customarily applied in treating and caring for the sick or wounded similarly suffering, and therefore constitutes malpractice.

CONCLUSIONS OF LAW

The Board finds that it has jurisdiction over the matter.

The Board finds the Respondent guilty of Counts One and Two, as alleged.

The Board finds the Respondent not guilty of Count Three. If any of the foregoing Conclusions of Law is more properly deemed as

a Finding of Fact, it may be so construed, or if the foregoing Findings of Fact is more properly deemed a Conclusion of Law, it may be so construed.

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law in good cause appearing,

IT IS HEREBY ORDERED that Respondent's license to practice medicine in the State of Nevada be hereby REVOKED and that the revocation be STAYED, and Respondent is placed on probation for a period of three (3) years subject to the following restrictions:

1. That Respondent cease performing laparoscopic surgeries immediately.

2. That all surgeries performed by Respondent, other than minor office procedures which can be safely performed in that setting, be performed in a JCAHO-approved health care facility, and Respondent shall be assisted by an American Board of Surgery certified surgeon duly licensed to practice medicine in Nevada.

3. That Respondent shall timely file with the Board a report concerning any surgery performed, including a copy of the history and physical, any laboratory tests and x-rays performed, the operative notes, and shall immediately report any adverse surgical outcomes.

4. That Respondent shall complete, in addition to other continuing education requirements imposed by law, 120 hours of medical education in the area of surgery approved in advance by the Secretary of the Board before the expiration of the Respondent's probation. Such continuing medical education shall include taking and successfully passing

the 1994 American College of Surgeons Surgical Education and Self-Assessment Program (SEESAP).

Dated this 23rd day of December, 1993.

NEVADA STATE BOARD
OF MEDICAL EXAMINERS

/s/Theodore Jacobs
by: Theodore Jacobs, M.D.
President

CERTIFICATION

I hereby certify that the foregoing is a full, true, and correct original FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER on file and of record in the office of the Board of Medical Examiners, in the matter of the Complaint against HARRISTON LEE BASS, JR., M.D., Respondent, Case No. 9455.

I further certify that Theodore Jacobs, M.D., is the President of the Board of Medical Examiners of the State of Nevada, and that full force and credit is due to his official acts as such; that the signature to the foregoing FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER is the genuine signature of the said Theodore Jacobs, M.D.

IN WITNESS WHEREOF, I have hereunto set my hand in my official character as Secretary-Treasurer of the Board of Medical Examiners of the State of Nevada.

DATED: This 29th day of December, 1993.

/s/Thomas J. Scully
Thomas J. Scully, M.D.

Secretary-Treasurer
Nevada State Board of
Medical Examiners

DISTRICT COURT
CLARK COUNTY, NEVADA
Filed Dec. 15 1994
Case Nos. A 328764 and 329186
Consolidated in Dept. No. XII

HARRISTON LEE BASS, JR., M.D.,)
Petitioner,)
vs.)
BOARD OF MEDICAL EXAMINERS)
OF THE STATE OF NEVADA;)
)

HARRISTON LEE BASS, JR., M.D.,)
Petitioner,)
vs.)
BOARD OF MEDICAL EXAMINERS OF)
THE STATE OF NEVADA, et. al.,)
Respondents.)
)

AMENDED ORDER REMANDING MATTER FOR CONSIDERATION OF ADDITIONAL EVIDENCE

This matter having come on for hearing on December 15, 1994, on Petitioner's Motion to Supplement Record on Appeal, Motion to Correct Index of Record; Motion for Court to Determine State of Record on Appeal Pursuant to Order of Court Dated May 24, 1994, and the Court having considered the pleadings of counsel, the record and the oral arguments of counsel, PAUL SORENSON, ESQ. counsel for Petitioner, and PAGE UNDERWOOD, ESQ., counsel for the Respondents, and good cause appearing, it is further

ORDERED that Volume XIV of the transcript , having inadvertently not been filed on the Record on Appeal, shall be submitted to

the clerk of the Court and made a part of the record herein, and it is further

ORDERED that this matter shall be remanded to the Nevada State Board of Medical Examiners to determine if additional matters would effect their decision; and it is further

ORDERED that the surgical admission slip from University Medical Center relating to Patient B should be considered by the Board; and it is further

ORDERED that the testimony of those individuals identified prior to the hearing who have direct personal knowledge regarding the surgical admission slip from University Medical Center concerning Patient B, including David Brandsness; and it is further

ORDERED that the Board should consider testimony that has been excluded, or at least an offer of proof of what would be testified to, in order to have a complete record; and it is further

ORDERED that the Board shall determine whether or not they desire to hear any additional testimony by the relatives of Patient B concerning the transfer of Patient B from Dr. Bass's care if the Board deems the testimony material and relevant; and the Board shall consider testimony with regard to the reason for substitution of doctors; and it is further

ORDERED that the Board should further consider documentary evidence offered by Petitioner at the hearing but not admitted as identified and listed in Exhibit #1 attached to the Amended Order; and it is further

ORDERED that the pleadings and other documents, identified and listed in Exhibit #2 attached hereto, shall be submitted by Petitioner and shall be made a part of the Record of Appeal; and it is further

ORDERED the Court finds the index to the Record on Appeal is sufficient to make a determination of where matters are in the record. However, an additional record should be supplemented to include testimony regarding the admission slip; and it is further

ORDERED that counsel for Petitioner may review all peer records considered by the peer review committees of all the hospitals involved; Desert Springs, Women's and University Medical Center; but Petitioner shall not be permitted access to any transcript of deliberations of the peer review committees; and it is further

ORDERED that Petitioner's attorney may talk to the family members to determine whether or not they should be allowed to testify before the Board.

THEREFORE, Petitioner's Motion to Correct Index of Record and Motion to Determine State of Record on Appeal Pursuant to Order of Court Dated May 24, 1994 is hereby denied and Petitioner's Motion to Supplement the Record is granted to allow the Board to consider additional testimony and documentation as outlined above in this Order, pursuant to NRS 233B.131(1).

Dated this 15th day of December, 1994.

/s/Myron E. Leavitt
MYRON E. LEAVITT
DISTRICT JUDGE

CERTIFICATE OF MAILING

I hereby certify that on the 15th day of December, 1994, I mailed a true and correct copy of the foregoing AMENDED ORDER REMANDING MATTER FOR CONSIDERATION OF ADDITIONAL EVIDENCE by placing a copy of

the same in a sealed envelope, postage prepaid thereon, addressed as follows:

Paul Sorenson, Esq.
513 South Sixth Street
Las Vegas, Nevada 89101

Page Underwood, Esq.
Attorney General's Office
401 South Third Street, #500
Las Vegas, Nevada 89101

/s/ Pamela Gunter
Judicial Secretary to
The Honorable Myron E. Leavitt

ORDR
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DISTRICT COURT
CLARK COUNTY, NEVADA
Filed August 26, 1996
Case Nos. A 328764 and 329186
Consolidated in Dept. No. XII

HARRISTON LEE BASS, JR., M.D.,
Petitioner,
vs.
BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA;

HARRISTON LEE BASS, JR., M.D.,
Petitioner,
vs.
BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA, et. al.,
Respondents.

ORDER ON ORDER RE:
PETITIONER'S MOTION TO PERMIT DEPOSITIONS PURSUANT TO ORDER OF REMAND,
Date of Hearing: 8-15-96
Time of Hearing: 9:00 a.m.

THIS MATTER HAVING COME ON FOR HEARING UPON Petitioner's Motion to Permit Depositions Pursuant to Order of Remand, and the Court having considered the pleadings on file

herein, as well as the argument of counsel, and good cause appearing therefor,

IT IS HEREBY ORDERED that the Petitioner is hereby granted the authority to take depositions for the purpose of providing offers of proof to the Board of Medical Examiners.

IT IS FURTHER ORDERED that the subpoena as to the investigator, Charles Romanello shall be limited to the process he went through and not he found out.

IT IS FURTHER ORDERED that Petitioner Bass' counsel shall have until 5:00 p.m. to provide the list of witnesses to the Deputy Attorney General to identify what subpoenas to issue.

IT IS FURTHER ORDERED that these subpoenas shall be issued no later than 5:00 p.m. on Monday, August 19, 1996 and provided to Petitioner Bass' counsel.

IT IS FURTHER ORDERED that Petitioner Bass shall have ten days thereater to take these depositions.

IT IS FURTHER ORDERED that Petitioner shall then make an offer of proof to the Board so that they make a determination whether or not these individuals should be subpoenaed for the hearing.

DATED this ___ AUG 26 1996

/s/ Myron E. Leavitt
DISTRICT JUDGE

/s/ R. Paul Sorenson
R. PAUL SORENSON
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Attorney for Petitioner

BEFORE THE NEVADA BOARD OF MEDICAL EXAMINERS
Filed 20 September 1996
Case No. 9455

In the Matter of the Complaint)
Against:)
HARRISTON LEE BASS, JR., M.D.,)
Respondent.)

ORDER AFFIRMING FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER AFTER CONSIDERATION OF ADDITIONAL EVIDENCE

Pursuant to the Amended Order Remanding Matter for Consideration of Additional Evidence dated December 15, 1994; Amended Order to Permit Depositions Pursuant to Order of Remand ordering the hearing to be held on September 7, 1996; and after previous orders by the Board attempting to set the hearings on January 21, 1995; May 6, 1995; November 4, 1995 and February 24, 1996, the remand hearing was held on September 7, 1996. Respondent was represented by his counsel, Michael Stuhff and Paul Sorenson and Respondent appeared in person, and The Board of Medical Examiners was represented by its counsel, Frankie Sue Del Papa, by and through her deputy, Jan J. Cohen, Senior Deputy Attorney General.

The Nevada State Board of Medical Examiners, (the "Board") was composed of Rex Baggett, M.D.; Susan Buchwald, M.D.; Kathy Ebner; Theodore Jacobs, M.D.; and Eva Simmons. The Board considered the additional evidence presented by Respondent as follows:

1. Patient B's Admission Slip was determined to have no relevance as to the ultimate demise of Patient B because the

pathology did not develop due to a five hour delay but had developed much sooner. The volvulus and its timing was not relevant to the prior determination of previous malpractice in the treatment of Patient B.

2. Board of Medical Examiners' Policy Book was determined immaterial, irrelevant and repetitious to the proceeding and the previous determination by the Board.

3. The handwritten notes of Dr. Gardner were not relevant to the proceeding because they were used in preparation of his affidavit which was already a part of the official record.

4. The affidavit and file of Dr. Gardner was determined to be irrelevant because the material had been entered into evidence at the previous hearing. No new information was presented and the Board had already considered and reviewed this information in its prior adjudication.

5. After consideration and review, Dr. Davidson's file was determined to be irrelevant because there was no way to determine that the material actually was from Dr. Davidson's file--the documentation was simply a memorialization of Dr. Davidson's file.

6. The Women's Hospital Medial Staff and By-Laws were not relevant or material to the Board's determination of medical malpractice. t The intervention of another physician in treating the patient was considered at the original hearing.

7. The statement of Dr. Wilson dated June 10, 1992 had previously been considered by the Board after the July 2, 1993 hearing and thus was determined to be repetitious.

8. The statement of Dr. Dunkin was determined to be irrelevant and immaterial because no new information was contained in this statement.

9. Dr. Plon's records were determined to be repetitious. The consults and Lab Data had been previous considered, and although the Board did consider the echocardiogram, it was determined to have no baring on the original decision. Lasar and laproscopic surgery are often confused by members of the public and Women's Hospital did not have echocardigram equipment capacity so that Dr. Plon would have had to obtain it independently. The x-rays had been considered at the previous hearing.

10. The Board considered Dr. Voss's affidavit but determined that the time sequence as to the presence of the volvulus had been considered carefully at length and that the finding of gross malpractice resulted from a sequence of events in Respondent's care of the patient and not an isolated event such as the volvulus.

11. The Board considered the affidavit of Donna Fleming and determined that it did not contradict any of the previous testimony of Dr. Fisher as to Respondent's treatment of the patient.

12. The affidavit of Susan Wright was considered and the Board determined that it had not previously accorded any weight to the gossip of the nurses; thus, the affidavit did not affect the original findings.

13. The deposition of Charles Romanolo was considered and recognized as is illustrative of counsel's contention of problems with evidence. Chain of custody is relevant to criminal procedure and not to an administrative

proceeding. In addition, the deposition was only applicable to the investigation of Patient B. This recognition did not affect the medical issues relevant to the Respondent's care of his patient.

14. The deposition of Robin McCarthy was not relevant to the remand of the administrative proceeding. Any comments made by the deponent were made after Respondent was no longer in charge of the patient's care.

15. The deposition of Cyril Blanchard was not relevant to Respondent's care of the patient.

16. The deposition of Michael McCallister was determined irrelevant to the Board's determination of malpractice. The Board found that there were no direct facts substantiating allegations of malfeasance on the part of other physicians.

17. The Board determined that the alleged offers of proof of Michael Stuhff dated September 4, 1996 were not relevant to the original decision. The alleged offers of proof did not add to the Board's understanding or provide new information as to the medical procedures employed and the Respondent's care of the patients at issue.

18. The Board considered the letter from Paul Sorenson to Dr. Juell dated September 4, 1996 and determined that it was not effective as to affect the issues of medical procedures employed by Respondent. The Board determined that the letter only stated that any doctor would not knowingly review records without a full set of records.

19. and 20. The Board considered the letter sent by the Executive Director as to the peer review of Respondent and the Board disciplinary policy definitions attached to the

letter and determined that no information was provided in these documents which could affect the previous decision.

21. The Board determined that the letters to the Board from Paul Sorenson dated August 23, 1996 and September 4, 1996 with an offer of proof of the testimony of Arlene Klepatsky were not relevant and the offer of proof contained no evidence of substantial omissions due tot he procedure employed as to the review.

IT IS HEREBY ORDERED that the original Findings of Fact, conclusions of Law and Order dated December 23, 1993 are reaffirmed (copy attached).

DATED this 18th day of September, 1996.

NEVADA STATE BOARD OF
MEDICAL EXAMINERS

BY:/s/Theodore Jacobs, M.D.
Theodore Jacobs, M.D.,
President

DISTRICT COURT
CLARK COUNTY, NEVADA
Filed June 5, 1997
Case Nos. A 328764 and 329186
Consolidated in Dept. No. XII

HARRISTON LEE BASS, JR., M.D.,
Petitioner,
vs.
BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA;

HARRISTON LEE BASS, JR., M.D.,
Petitioner,
vs.
BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA, et. al.,
Respondents.

EXCERPT OF
REPORTER'S TRANSCRIPT OF PROCEEDINGS
THURSDAY, May 22, 1997

Before the Hon. Myron E. Leavitt, District Judge
(oral decision on Petition for Judicial Review)

MS. NIELSEN:

. . . .

With respect to the records, there are allegations that records are missing, destroyed, altered, shredded, et cetera, et cetera. The first question I would like to ask, now - - and as I'll argue, it's not true, records have not been destroyed, have not been altered and there are no missing records. The question that I would like to ask is what they have established? No one has even told you, Judge, what that smoking gun is that's out there someplace.

THE COURT

Because they don't know. Because they don't know what they'll show because they haven't seen them.

MS. NIELSEN

Well, it doesn't establish that this care was proper.

THE COURT

Well, I'm not assuming that it's a smoking gun and it will be the matter that would determine the case, but it does trouble me that some of the hospital records are not available.

MS. NIELSEN

Okay. May I address it?

THE COURT

I can't make the decision, in other words, if the hospital records would clear Dr. Bass if he had them because I don't necessarily think that's true. It just creates a problem by not having them.

MS. NIELSEN

Okay. Judge, as you're aware, all three of the custodians of records testified that the records were true, accurate and complete, so we have testimony of all three of those custodians of records, that's for Women's Hospital, Desert Springs and UMC.

THE COURT

The problem with that is you're right, that's what they certify. There's full and complete records. And then Dr. Plon comes up with some records in a trunk of a car which were not included, even though they had a certification that those were the complete records. So, you know - -

MS. NIELSEN:

And, Judge, you know, I'm sure than an explanation might be appropriate that, Judge, these records were given to Dr. Plon and did not

go into Desert Springs Hospital records, but that does not show - - that does not necessarily show that we have people who are being dishonest to the Court or that those records - - it doesn't even show that his care was proper. The records that do turn up in her car don't show anything.

THE COURT

As I said earlier, I don't think it's necessarily a smoking gun - -

MS. NIELSEN

Correct.

THE COURT

- - but it is certainly a concern that the hospital records are stored in the trunk of a doctor's car and show up all of a sudden when she's asked in a hearing in front of the Medical Board of Nevada Examiners - - Nevada Board of Medical Examiners. That's just a concern. I'm not saying that it proves anything.

MS. NIELSEN

My I also suggest that Dr. Plon's and UMC's records and that discrepancy should be attributed to the Board of Medical Examiners who were not involved in it.

THE COURT

I understand that, but the question of course is did he get a fair and open hearing.

MS. NIELSEN

Yes.

THE COURT

See, that's the question. But if you get certifications from people saying they're full and complete records and then a doctor comes up and says, Well, wait a minute, I've got some of the records in the trunk of my car, let's bring those in and consider those and then some of the records are shredded.

MS. NIELSEN

Okay. May I respond to that?

THE COURT

Yes.

MS. NIELSEN

First of all, I also want to point out, though, that all of the records were provided to Dr. Bass very early on as to Patient A in 1990 and as to Patient B in 1992.

MR. SORENSON

Your Honor, now I hate to interrupt, but that's just not true, the records do not - -

THE COURT

I understand what the record shows. Go ahead.

MS. NIELSEN

And, also, Judge, may I say, too that I read all of Dr. Plon's testimony and I don't get the same list of missing records that counsel gets from it.

THE COURT

But there's no question she had some records in her trunk?

MS. NIELSEN

She had records, yes.

THE COURT

Okay

MS. NIELSEN

With respect to Larry Leslie's testimony, he's the Board's prosecutor, and he was the first witness to testify, and these are the allegations that there were documents shredded. It is the Board's practice, and it was Larry Leslie's testimony, that in every case once the investigative committee determines that there is sufficient evidence to investigate a case such as this, it goes to the hospitals and obtains medical records and then makes multiple copies of those records and then circulates them among medical

reviewers that look at the records. The medical reviewers then write on them, shuffle them, throw some away and send some back. Oftentimes they are picked up. The Board destroys these records and later obtains new certified copies of the records.

Now, the reason this makes sense is that if the Board retained the copies that the doctors reviewed, it would come to this hearing with stacks and stacks of documents and records, multiple copies of the same thing with doctors' notes, with portions missing, with the copies having been completely shuffled. It makes the most sense and it's a very common practice. And I don't think that there's anything sinister about the Board's practice of going back to the hospital when it is determined that they will go forward and obtain certified copies and then show the doctors those certified copies, the doctors that will be testifying. There isn't any difference between these records that show somehow that the care was proper. So the only records that have been testified to that were destroyed are duplicate copies.

With respect to Dr. McGregor, it is suggested that Dr. McGregor's testimony was supported - -

THE COURT

This is the Reno doctor, right? This is the doctor from Reno - -

MS. NIELSEN

Yes.

THE COURT

- - that made the statement that he didn't find any malpractice?

MS. NIELSEN

Yes.

THE COURT

Okay

MS. NIELSEN

Now, I don't know - - all there is at this point is just a suggestion that the set of records provided to Dr. McGregor are somehow different than the ones that were ultimately used at the hearing, but there is no evidence of that.

. . . .

MS. NIELSEN

. . . .

With respect to the destroyed records, we've already established through Larry Leslie's testimony and Brian Juell's testimony that the only records destroyed are duplicate originals. So the situation with Mishler is a very different situation. We have complete records here. All we have is basically a bald statement that there are missing records out there someplace.

. . . .

Dr. Bass is asking the Court to substitute its judgment here based on supported allegations of missing and altered records.

. . . .

THE COURT

As to Patient A?

MS. NIELSEN

As to Patient A.

THE COURT

Okay.

MS. NIELSEN

So we would like to ask the Court to deny Dr. Bass's petition for judicial review of the Board's disciplinary order which includes the three years' probation.

THE COURT

Final

MR. SORENSON

Your Honor, let me just briefly respond to her. Relative to how this case started out, she made some bold statements that we were immediately provided in 1990 with the records in this case. So this Court understands, Dr. Bass did not have them until one week before this action commenced at trial. That is a boldfaced misstatement - -

THE COURT

You mean the hearing?

MR. SORENSON

Before the hearing, that's correct?

THE COURT

You said trial

MR. SORENSON

Well, the hearing in front of the Board of Medical Examiners.

We were not provided any discovery. We attempted to get discovery ad nauseam, and we had to conduct our discovery during the hearing. It was the only way possible. It was during that time that we discovered that there was massive missing records. Right now if you look at the records there's about 60 percent of records that she claims are wonderful, complete and true. There are no x-rays. Judge, no x-rays. No x-ray reports. All removed in Patient A.

Now, what were they looking at when they were giving these opinions? The moon? Does she respond to that, no. It's outrageous misconduct she's sitting here doing today. She is misstating the record time and time and time again.

THE COURT

Counsel, I don't want you to attack opposing counsel. Just tell me what your situation is and what the argument is.

MR. SORENSON

The argument is when we started out with a project to defend Dr. Bass with no tools that we customarily have, we have two malpractice cases where we have to do our discovery and how it affects us in open court where we have to call everybody whether we like them or don't like them to find out what the heck they did, to find out what records they looked at, and we found out that there were looking at incomplete sets. And we show it conclusively on the record that that's the fact, and the Board won't look at the correct set. What more can we do? That's gross misconduct.

Now, lets talk about Patient A, what really happened. Now, if the Court is confused after I get done, Dr. Bass here can address the Court relative to what really happened with Patient A.

THE COURT

I can't take testimony.

MR. SORENSON

Well, let me tell you what the records show. Dr. Bass testified clearly and distinctly at that. He knows what happened to the patient. Let me tell you what happened.

THE COURT

Is this in the record or what he told you?

MR. SORENSON

This is in the record.

THE COURT

Okay.

MR. SORENSON

Very simply, and I could summarize it for you very quickly.

NO. 1, the patient was operated on by Dr. Bass laparscopically. When we had the intra - - what's the correct word? The bleed in the abdominal wall. He had to do an open laparotomy to look at what he had worked on to

make sure there was no bleeding. So all of this -- and it was - - the bowel was run, there were no bleeds.

So what we have is we have what we call -- we people who knew Harry Truman and heard him - - we call it a red herring about the fact that these people didn't know about laparoscopic surgery and so now they're criticizing the technique.

Dr. McGregor correctly said Look, there are different surgeons and there are different ways to approach the problem. Here's what happened then after it - - which is the only thing that's significant, Your Honor. After Dr. Bass ran the bowel, closed the patient and the postoperative procedure commenced, the only problem the patient had was a fluid problem. Dr. Bass, and everybody agrees, he corrected called in Dr. Plon to manage the fluids. That dame in about noon on the day before she was transferred from Women's Hospital to Desert Springs Hospital.

At that point in time Dr. Bass's real treatment of the patient ceased. Then what happened to this patient? At about 3:00, Dr. Plon inserted a CVP line. Prior to - - immediately prior to the CVP line being inserted, the records well reflect this patient's lungs were clear, she was in no acute distress, and within 30 minutes after that CVP line her lungs became junky and she now became guarded.

This was after a procedure that was performed by Dr. Plon. Dr. Plon has conveniently removed her notes, or somebody has removed her notes concerning what she did and what she found.

Approximately an hour later she also did an echocardiogram. All of those records are removed.

THE COURT

They weren't in the trunk of her car?

MR. SORENSON

Well, parts of it were in the trunk of her car, yes. That's how we found out about it.

But there's no records in the official record about it. How could the experts who are forming their opinion - they're taking a leap frog back because they didn't know about the problem that occurred when this CVP line was inserted. The records document it clearly and distinctly what happened to Patient A, but there were removed from the record to place the blame on Dr. Bass.

But let's take it one step further. Neither did she call Dr. Bass and say I just screwed your client up severely, she left him out hanging. Now we don't know what she was doing.

And during the hearing the Court understands we were conducting discovery, we were under pressure. I was threatened with bar sanctions by the judge who was running the proceedings because I had the audacity to accuse the person who was forging the records, because that's what they were doing. And I was under constant pressure to do what we call offers of proof concerning people that I had no right to take discovery from with threats that I was going to go to the Bar Association.

THE COURT

Well, I will sympathize with you, but I want to get this darn there over with.

MR. SORENSON

When - -

THE COURT

We don't want to mention what's happening in other cases because I'm going to limit you to two more minutes because I have a jury trial waiting. Go ahead. I don't want to hear about what's happening in other cases or sanctions or anything like that. What I want to do is limit it to the evidence in this case.

MR. SORENSON

I really honestly can't conclude Patient A and respond to her in two minutes, Judge, and I would be happy to come on back and go through - -

THE COURT

Well, I'm going to finish this today. You've already had over an hour to set forth your position and I've read the briefs. I've read the record. I'm ready to rule.

MR. SORENSON

What I was going to point out to the court, in the Mishler case on page 294, it gives the court clear authority to look at these serious record violations and as the impact, the ability to defend this case and grant you authority to dismiss it has to be the ruling.

THE COURT

Okay.

MR. SORENSON

They cite a case Stubli versus Big D International Trucks, 107 Nevada, 309, set forth in the study it says, we also set forth a nonexhausting list of factors which a court may properly consider in deciding whether dismissal of a complaint is appropriate, and it's not limited to just the Supreme Court. That's what I'm point out, but let me finish, just so you could understand.

Dr. Bass did not have care of this patient during this time, just like in Patient B is what we

call when the mess ups occurred, and this is what they're trying to blame Dr. Bass for. I use this example because I think it's the correct way to do it. Dr. Bass pointed out when he was called at early morning on the 20th, he did the examination of the patient, made a determination that nothing was going down the abdomen, but determined that there had been an enormous insult to the lungs since he saw the patient last. We now know it occurred when Dr. Plon put in her CVP line.

He says Dr. Plon and Choudhury, Please look at the lung. Make sure there's nothing going on the lung. . . .The autopsy shows it should have went that way because ARDS killed this patient. What's even more significant is ARDS wasn't treated for some two to three weeks after that.

ARDS is a deadly disease process in a human being. The mortality rate is roughly 80 percent for them to not treat ARDS, and to assume that he had done something wrong is, in fact, gross malpractice. That's in the record.

THE COURT

Okay.

MR. SORENSON

And then to attack and remove from the record the piece of evidence that proves what we're saying is true is they removed the CAT scan. As you've heard counsel say here so eloquently, that we had a doctor in here trying to protect - - describe leaking bowels, right, the CAT scan which was done with oral contrast shows none. Shows none, Judge. And in spite of that, he went and chopped her and killed the patient and I know why he decided he needed to change the records, to frame Dr. Bass. That's what's in the records.

THE COURT

Okay. First of all, as I said at the beginning of the hearing, the Court is precluded from substituting its judgment for that of the Board of Medical Examiners in this case. And I must affirm the decision if the decision is supported by substantial evidence on the record.

As to Patient A, I do find that there is substantial evidence in the record to support the penalty issued by the Board, and that is conclusive, and that it is not conclusive as to the penalty that was supplied to the - - that was given to the doctor, and that is conclusive and not arbitrary or capricious.

As to Patient B, I find that there is not substantial evidence in the record to justify the penalty imposed. That the action against Dr. Bass as to Patient B was arbitrary and capricious, and he properly diagnosed the problem. He wanted to operate on Patient B and was prevented from doing so, and I don't see how that could be malpractice, especially since the delay in the operation was a major cause of the death. So, as to Patient B, I find that there is not substantial evidence to support the penalty, but as to Patient A, I find there is substantial evidence to support the penalty, and therefore the petition for review is denied.

ORDR
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DISTRICT COURT
CLARK COUNTY, NEVADA
Filed June 20, 1997
Case Nos. A 328764 and 329186
Consolidated in Dept. No. XII

HARRISTON LEE BASS, JR., M.D.,
Petitioner,
vs.
BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA;

HARRISTON LEE BASS, JR., M.D.,
Petitioner,
vs.
BOARD OF MEDICAL EXAMINERS OF
THE STATE OF NEVADA, et. al.,
Respondents.

ORDER ON PETITION FOR JUDICIAL REVIEW

The Petition for Judicial Review filed in the above matter having come on for hearing on May 22, 1997, Petitioner Harriston Lee Bass, Jr., M.D. having appeared personally and through counsel R. Paul Sorenson, Esq. and Michael V. Stuhff, Esq., and Nevada State Board of Medical Examiners having appeared through counsel,

Senior Deputy Attorney General Leslie A. Nielsen; the Court having consiered arguments of counsel, the papers filed herein and the administrative record on file; ad Respondent having filed a Motion for Clarification or Rehearing; and good cause appearing therefor,

IT IS HEREBY ORDERED that:

1. Respondent's Motion for Clarification or Rehearing is granted;

2. The charged violation of NRS 630.301(4) in Count One for gross malpractice in the care and treatment of Patinet A is supported by clear and convincing evidence and is affirmed;

3. The charged violation of NRS 630.301(4) in Count Two for malpractice in the care and treatment of Patient B constituting repeated malpractice is not supported by clear and convincing evidence, is arbitrary and capricious, and is set aside; and

4. This case is remaneded to the Board to decide what sanction, if any, should be imposed on Count One which was supported by the evidence.

DATED this ___ day of June 20, 1997, 1997.

/s/ Myron E. Leavitt
DISTRICT COURT JUDGE

Submitted by
FRANKIE SUE DEL PAPA, Attorney General
by/s/ Leslie A. Nielsen
Leslie A. Nielsen
Senior Deputy Attorney General
Nevada Bar No. 2764
555 E. Washington Ave., Rm. 3900
Las Vegas, Nevada 89101

N THE SUPREME COURT OF THE STATE OF NEVADA
Filed December 03 1999
Case No. 30632

HARRISTON LEE BASS, JR., M.D.,
Appellant/Cross-Respondent,
vs.
STATE OF NEVADA, BOARD OF MEDICAL EXAMINERS,

Respondent.

ORDER

This matter is currently scheduled for oral argument on December 16, 1999, at 10:00 a.m. in Carson city before the en banc court. On December 1, 1999, appellant filed a motion to supplement the record on appeal. Appellant seeks to supplement the record with various affidavits, narratives and letters. Appellant has attached the proposed supplemental record as exhibits to the motion.

Our review of appellant's proposed supplemental record indicates that the documents were never presented to or considered by the district court below.[1] Accordinly, cause appearing, we deny appellant's motion. See Carson Ready Mix v. First Nat'l Bk., 97 Nev. 474, 635 P.2d 276 (1981) (our review of the record is limited to those documents which were presented to or considered by the district court in reaching the decision appealed from). Furthermore, we direct the clerk of this court to

[1] Most of the affidavits were only recently obtained and are dated well after the notices of appeal were filed herein.

forthwith strike the exhibits attached to appellant's motion.

It is so ORDERED.

/s/Rose ,C.J.

cc: Attorney General
Leslie A. Nielsen, Senior Deputy Attorney General
R. Paul Sorenson
Michael V. Stuhff

IN THE SUPREME COURT OF THE STATE OF NEVADA
Filed September 18, 2000
Case No. 30632

HARRISTON LEE BASS, JR., M.D.,)
Appellant/Cross-Respondent,)
vs.)
STATE OF NEVADA, BOARD OF MEDICAL)
EXAMINERS,)
Respondent/Cross-Appellant.)

ORDER DENYING REHEARING

Rehearing denied. NRAP 40(c).
It is so ORDERED.[1]

/s/_ROSE_____, C.J.
Rose

/s/_YOUNG_____, J.
Young

/s/_MAUPIN_____, J.
Maupin

/s/_SHEARING_____,J.
Shearing

/s/_AGOSTI_____,J.
Agosti

/s/_BECKER_____J.
Becker

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[1] The Honorable Myron E. Leavitt, Justice, voluntarily recused himself from participation in the decision of this matter.

cc: Hon. James C. Mahan, District Judge
Attorney General
Leslie A Nielsen, Deputy Attorney General, Las Vegas
R. Paul Sorenson
Michael V. Stuhff
Clark County Clerk

CONSTITUTIONAL PROVISIONS, STATUTES AND REGULATIONS INVOLVED IN THIS CASE

United States Constitution, Amendment V - Rights of Persons

> No person. . .shall be deprived of life, liberty or property, without due process of law. . .

United States Constitution, Amendment XIV, Section 1, Rights of Citizens

> ***No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Nevada Revised Statutes 233B.135 Judicial review: Manner of conducting; burden of proof; standard for review.

> "3. . . . .The court may remand or affirm the final decision or set it aside in whole or in part if substantial rights of the petitioner have been prejudiced because the final decision of the agency is:
>
> (a) In violation of constitutional or statutory provisions;

(b) In excess of the statutory authority of the agency;
(c) Made upon unlawful procedure;
(d) Affected by other error of law;
(e) Clearly erroneous in view of the reliable, probative and substantial evidence on the whole record; or
(f) Arbitrary or capricious or characterized by abuse of discretion.

Nevada Revised Statutes 233B.135 Judicial review: Manner of conducting; burden of proof; standard for review.

(1)(b). . . .In cases concerning alleged irregularities in procedure before an agency that are not shown in the record, the court may receive evidence concerning the irregularities.

Nevada Revised Statutes 233B.150. Appeal from final judgment of district court.

An aggrieved party may obtain a review of any final judgment of the district court by appeal to the supreme court. The appeal shall be taken as in other civil cases.

Nevada Administrative Code 630.252 "Gross malpractice" interpreted (NRS 630.130).

For the purposes of NRS 630.301, as that section existed before October 1, 1997, a physician shall be deemed to have committed gross malpractice, if, before October 1, 1997 he has failed to exercise the required degree of care, skill or knowledge and such failure amounts to:

1. A conscious indifference to the consequences which may result from malpractice; and

2. A disregard and indifference to the safety and welfare of a patient.

Nevada Revised Statutes 51.135. Record of regularly conducted activity.

A memorandum, report, record or compilation of data, in any form, of acts, events, conditions, opinions or diagnoses, made at or near the time by, or from information transmitted by, a person with knowledge, all in the course of a regularly conducted activity, as shown by the testimony r affidavit of the custodian or other qualified person, is not inadmissible under the hearsay rule unless the source of information or the method or circumstances of preparation indicate lack of trustworthiness.

Nevada Revised Statutes 51.145. Absences of entry in records of regularly conducted activity.

> Evidence that a matter is not included in the memoranda, reports, records or data compilations, in any form, of a regularly conducted activity is not inadmissible under the hearsay rule to prove the nonoccurrence or nonexistence of the matter, if the matter was of a kind of which a memorandum, report, record or data compilation was regularly made and preserved.

Nevada Revised Statutes 630.301. Grounds for initiating disciplinary action or denying licensure:

> The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure. . . .(4) Malpractice, which may be evidenced by claims settled against a practitioner.

Nevada Revised Statutes 630.306. Grounds for initiating disciplinary action or denying licensure:

> The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure. . . .(6) Performing, without first obtaining the informed consent of the patient or his family, any procedure or prescribing any therapy which by the current standards of the practice of medicine are experimental.

Nevada Revised Statutes 630.306. Grounds for initiating disciplinary action or denying licensure:

The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure. . . .

1. Failure to maintain medical records relating to the diagnosis, treatment and care of a patient.
2. Altering medical records of a patient.
3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.

Nevada Administrative Code 630.210. Consultation with another provider of health care.

A physician shall seek consultation with another provider of health care in doubtful or difficult cases whenever it appears that consultation may enhance the quality of medical services.

Nevada Administrative Code 630.230. Prohibited professional conduct.

A physician shall not:

(a) Falsify records of health care

. . . .

Nevada Administrative Code 630.260. Notice of technical or scientific facts.

Parties to a disciplinary hearing before the board will be notified,

either before or during the hearing, of supposed technical or scientific facts of which the board may take notice, and the parties will be afforded an opportunity to contest those facts. The board's experience, technical competence and specialized knowledge may be utilized in the evaluation of evidence.

Nevada Administrative Code 449.376
Hospitals: Radiology Department

. . . .4. Hospitals must have a qualified radiologist to interpret all films. . . .Signed reports must be filed with the patient's record. Duplicate copies must be kept in the department. . . .

Nevada Administrative Code 449.379
Hospitals: Medical Record

. . .3. If applicable, records must include the following:
. . . .(v) History and physical examination
. . . . (y) Laboratory reports of all tests completed.
(z) Reports of all X-rays completed.
(aa) Complete surgical record, including anesthesia record, preoperative diagnosis, operative procedure and findings, postoperative diagnosis and tissue diagnosis on all specimens surgically removed.

Nevada Revised Statures 449.705. Facility required to forward patient's medical records upon transfer of patient form facility.

1. If a patient in a medical facility or facility for the dependent is transferred to another medical facility or facility for the dependent, a division facility or a physician licensed to practice medicine, the facility shall forward a copy of the medical records of the patient, on or before the date the patient is transferred, to the other medical facility or facility for the dependent. .

. .

2(b)

. . . .

"Medical records" includes a medical history of the patient, a summary of the current physical condition of the patient and a discharge summary which contains the information necessary for the proper treatment of the patient.

IN THE SUPREME COURT OF THE STATE OF NEVADA
Filed September 04 1992
Case No. 23567

HARRISTON LEE BASS, JR., M.D., Petitioner,	)
vs.	)
HONORABLE JACK LEHMAN, EIGHTH JUDICIAL DISTRICT COURT JUDGE, Respondent.	)
and	)
BOARD OF MEDICAL EXAMINERS OF THE STATE OF NEVADA, et. al. *Real Parties in Interest*	)

PETITION FOR ISSUANCE OF WRIT OF PROHIBITION AND/OR FOR AN ALTERNATIVE WRIT OF MANDATE

TO: The Honorable Justices of the Supreme Court of the State of Nevada:

COMES NOW, HARRISTON LEE BASS, JR.,M.D., Petitioner, by and through his attorney, R. PAUL SORENSON, and petitions this Court for the issuance of a Writ of Prohibition and/or for an Alternative Writ of Mandate and respectfully shows:

STATEMENT OF FACTS

Background of Action and Procedural Background

HARRISON LEE BASS, JR., M.D. is a board certified general surgeon and is currently licensed in the State of Nevada. The Respondent Board has filed a public complaint (prior to affording Dr. Bass "peer review" in accordance with an unwritten policy affording the same to

most other physicians) alleging gross malpractice against Petitioner Bass for alleged incidents occurring during July of 1990. BAS denies any malpractice, much less gross malpractice and his position is supported by qualified medial practitioners. **All discovery has been denied by the Board**. Failure to provide discovery will result in a very long or very unfair hearing and probably both as it flies in the face of all current judicial thinking concerning discovery and the Board's own **unwritten** "open-file" policy **afforded all other physicians**. The Complaint was filed on June 5, 1992, a copy of which is attached hereto as **Exhibit 1**.

BASS filed a motion on July 6, 1992 that the Board recuse themselves for actual bias and prejudice and refer the matter to an impartial hearing body for further proceedings on in the alternative to dismiss the same. That motion was summarily denied by the Board without having an opportunity to be heard on the same day they received it. A copy of the Motion is attached hereto as **Exhibit 2** and a copy of the Order denying the same is attached as **Exhibit 3**.

The matter was assigned on or about July 17, 1992 to a Hearing's Office in Reno, Nevada and the matter scheduled for a hearing on September 14, 1992 in Reno, Nevada. A copy of that notice of hearing is attached as **Exhibit 4** That BASS filed a Petition for Judicial Review of the Order denying his Motion that the Board recuse themselves (**Exhibit 4A**). That BASS made motions to the Hearing's Officer for stay of proceedings pending the petition for judicial review; motion for continuance due to a death and illness in counsel for BASS' family motion

for discovery and list of witnesses the Board anticipated calling; and for change of venue (**Exhibit 5**). This was opposed by the prosecutor for the Board (**Exhibit 6**); a reply made by Petitioner BASS (**Exhibit 7**) and all motions were ultimately denied by the Hearings Officer without hearing on (**Exhibit 8**).

That, anticipating that the Hearings Officer would deny his motions, BASS moved the Court on August 26, 1992 in the Petition for Judicial Review proceedings for an Order Staying Proceedings Before Board of Medical Examiners of the State of Nevada Pending Ruling on Petition for Judicial Review (**Exhibit 9**). This was opposed by the Respondents (**Exhibit 10**). Petitioner then filed a Reply and Motion to Supplement Petition for Judicial Review to include the subsequent rulings before the Board, which related to the Hearing's Officer summarily turning down all of Petitioner's motions without hearing (**Exhibit 11**).

A hearing was held before Judge Lehman on September 1, 1992. The judge executed an order prepared by Respondent's counsel (**Exhibit 12**) and refused to sign the order prepared by BASS (**Exhibit 13**). Judge Lehman further denied BASS ex parte application to stay the Board's proceedings pending our application for extraordinary relief (**Exhibit 14**).

Three is no plain, adequate and speedy remedy at law and extraordinary relief is necessary for the following reasons:

(a) The decision of the Board, Hearings Officer and Judge Lehman had to include (although not spelled out) a finding as a basis for the decision that the Board is not required to adopt written rules of

practice of all formal and informal procedures for disciplinary proceedings as required by NRS 233B.050.

(b) That BASS is required at this juncture to go forward with a hearing without any discovery (even though there is an un-written rule for an open-file discovery policy with the Board) and further without knowing who the witnesses against BASS will be and what evidence they have to support their serious charges made against him.

(c) That BASS Must persuade his witnesses to voluntarily appear at an unknown place in Las Vegas or Reno for a hearing of indeterminate length.

(d) That failure to give BASS a fair hearing concerning his challenge to the medical board for bias and further permitting a proceeding to go forward without the most basic due process procedural fairness can only result in extreme damage to BASS from which there is no recovery and irreparable harm.

(e) That the proceedings filed against BASS could result in limits of his practice or a suspension or revocation of his medical license. NRS 630.356 provides that in the event this occurs the Court shall not stay the order of the board pending a final determination by the Court.

STATEMENT OF ISSUES

1. Is the Board permitted to carry on disciplinary proceedings against a

practitioner without having first adopted and published written rules and regulations of all formal and informal proceedings pursuant to NRS 233B.050?

2. Should there be an orderly process to determine whether or not the Board has actual bias and prejudice against the practitioner? Has BASS already demonstrated that the Board has actual bias so as to disqualify them.

3. When the Board has an unwritten open file policy with regard to discovery for other practitioners undergoing disciplinary proceedings, should they be permitted to deny Dr. Bass the same right? Does this denial of that same right demonstrate bias and prejudice and denial of due process?

4. With regard to the issue of venue, should the Board be required to pass written rules and regulations concerning the place of venue, particularly considering the fact that the Board has Hearings Officers in place in both Reno and Las Vegas?

5. Should the Hearings Officers for the Board of Medical Examiners be appointed in a manner similar to the other agencies or should they be appointed by the Board and under their control.

6. Should the authority of the Hearings Officer be established in written rules properly enacted pursuant to NRS 233B, the *Administrative Procedure Act.*

RELIEF SOUGHT

1. A mandate for the Board and its Hearings Officers to stay all proceedings in Case No. 9455 pending the adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process

procedural requirements for the conduct of disciplinary hearings including:

(i) sufficient time notice of a hearing to enable an accused to adequately prepare for hearing with due regard for the complexity of the issues, witnesses and evidence, i.e., not less than 30 days together with provisions for continuances which may be granted for good cause.

(ii) procedures allowing for discovery of witnesses and evidence upon which the Board may rely at the hearing.

(iii) procedures for the taking of depositions or discovery of the opinions of witnesses whose opinions may be relied upon at the hearing.

(iv) time allowed for the hearing with due regard for the rights of all parties to present witnesses and evidence..

2. A mandate for the Board and its Hearings Officers to stay all proceedings in Case No. 9455 pending the adoption of written rules and regulations establishing a procedure for determination of place of venue.

3. A mandate for the Board and its Hearings Officers to stay all proceedings pending the adoption of rules governing procedures for alleging bias against the Board.

4. A mandate for the Board and its Hearings Officers to provide Dr. Bass with all of the same procedures and remedies provided other physicians.

5. An order prohibiting the Board and its Hearings Officers from proceedings with its

disciplinary action against BASS prior to the adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minor due process procedures for the conduct of disciplinary hearings.

STATEMENT OF REASONS AND POINTS AND AUTHORITIES IN SUPPORT OF GRANTING RELIEF SOUGHT

I.

The Due Process and Equal Protection Clauses of the United States and Nevada Constitutions do not permit the Board of Medical Examiners to Carry on Disciplinary Proceedings Without having First Adopted written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings.

NRS 233B.050 provides as follows:

"1. In addition to other regulation-making requirements imposed by law, each agency shall:

(a) Adopt rules of practice, setting forth the nature and requirements of **all** formal and informal procedures available, including a description of all forms and instructions used by the agency.

(b) Make available for public inspection all regulations adopted or used by the agency in the discharge of its functions and that part of the Nevada Administrative Code which contains its regulations."

(c) Make available for public inspection all final orders, decisions and opinions except those

expressly made confidential or provided by statute.

(d) Review its rules of practice at least once every 6 years and file with the secretary of state a statement setting forth the date on which the most recent review of those rules were completed and describing any revisions made as a result of the review.

2. No agency regulation, rule, final order or decision is valid or effective against any person or party, nor may it be invoked by the agency for any purpose, until it has been made available for public inspection as required in this section, except that this provision does not apply in favor of any person or party who has actual knowledge thereof."

(emphasis provided)

The Board has failed to adopt of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings. The affect of this on an accused physician and his counsel attempting to set forth a defense is devastating for the reason that the Board and the Hearings Officer are at liberty to change the rules and do change the rules regularly (Affidavit of Sorenson) on an individualized basis.

By failing to adopt written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings, the parties and the Hearings Officer do not even know what kind of authority the Hearings Officer has. In the Order

of Hearings Officer Legarza (**Exhibit 8**) he states that he has "appointed authority to rule on **procedural** and **not substantive motions**. . ." What is procedural and what is substantive? We happen to believe that the matter of venue and providing BASS with the same discovery all other physicians receive are constitutional rights and are substantive. This came up in earlier proceedings between the Board and BASS wherein another Hearings Officer, Pat Dolan stated:

> "MR. DOLAN: All right. And I think I talked to you yesterday that those would have to be addressed to Mr. Haight. Because the **only mandate** that I have from the Board and **the only authority they have given me is to preside over a fact-finding hearing** that is currently scheduled to be held this next week and, at that time, to receive into evidence the factual record and to then transmit the certified shorthand reporting transcript of the proceedings together with any evidentiary documents that are received at the time of the hearing to the Board with a synopsis of the record for the Board, then to digest the factual basis and to also then consider and rule on any legal issues.
>
> And unfortunately, or fortunately, depending on your point of view, that is the **limit of what authority I've been delegated at the present time.**" (Transcript, 2-19-88, Page 4,-emphasis provided)

At the same hearing, Hearing's Officer Dolan was even questioned by Board Counsel, Mr. Lessly, of his power to authorize the issuance to Petitioner Bass of subpoenas in blank:

> "MR. SORENSON: I made a request of the Hearings Officer for authority to have subpoenas issued in blank. He indicated to me that I had that authority.
> MR. LESSLY: Is that correct, Mr. Dolan?
> MR. DOLAN: Yeah, I didn't know there was any problem. But I don't know if there was a problem before. I think your question went to whether or not there's an initial problem.
> MR. LESSLY: You're the second person he asked to have that done. They advised him there was no legal authority to do that.
> MR. SORENSON: I advised the Hearings Officer of 630.140 which specifically authorizes--in fact, I think compels--the Hearing Officer to authorize the issuance."

Without adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings, there will be continued doubts on what a Hearings Officer can and cannot do. What happens at a hearing where there is the necessity of a ruling with regard to a "substantive issue?"

The issues of venue, discovery, peer review, time, hearings of motions, and consideration of motions are all subject to arbitrary action simply because there are no written rules. A hearing without these

procedural safeguards is absolutely meaningless. The due process clause of the Fifth and Fourteenth Amendments to the United States and Nevada Constitutions and the equal protection clause of the Fourteenth Amendments to the United States and Nevada Constitutions require that the State of Nevada pass laws which provide for fair hearings and those laws be equally applied to all of its citizens. The practice of a profession is, without question, a valuable property right, of which one cannot be arbitrarily denied. State v. Medical Examiners, 68 Nev. 455, 235 P.2d 317 (1951), Schware v. Board of Bar Examiners, 353 U.S. 232 (1957). "The Supreme Court has emphasized that 'due process is flexible and calls for such procedural protections as the particular situation demands.'" Morrissey v. Brewer, 408 U.S. 471, 481 (1972). To determine appropriate procedure, we must consider: (1) the private interest affected; (2) the risk of erroneous deprivation by the procedures used; and (3) the government interest to be protected in light of the fiscal and administrative burdens imposed by additional procedural safeguards. Matthews v. Eldridge, 424 U.S. 319, 335 (1976).

This issue is of such importance that it was considered in the first Attorney General Opinion in the State of Nevada. In a letter to the Secretary of the Nevada State Board of Medical Examiners on May 5, 1914, Attorney General George B. Thatcher wrote:

> Notwithstanding the possible existence of these causes of revocation of license, I do not think the existence of such causes *ipso facto* works such revocation. The person in question is entitled to

have a formal complaint lodged against him before your board and to have due notice thereof so that he may show cause why such license should not be revoked, if any he has, and to introduce such evidence in his own behalf as he may see fit. Otherwise he would not be accorded the "due process of law" afforded him by both our State and Federal Constitutions. The revocation of his license as a physician, the means by which he acquires his livelihood, is certainly the taking of property, and no property can be taken from a person without due process of law. Under these circumstances, if the matter is to be pursued further, I would suggest that your board can proceed legally only in the manner above outlined."

Attorney General Opinion 1 (1914)

Of course, due process requirements have been necessarily expanded since 1914 primarily in the area of discovery and in the area of pre-screening complaints to prevent the damage which occurs when making the same public.

The Board has failed to adopt written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings. Due process cannot be satisfied when the Board is permitted to violate the mandates of the Nevada Legislature. Equal protection cannot be afforded Dr. Bass when he is selectively deprived of certain unwritten procedural rights granted other physicians.

II.

Bass is Entitled to an Orderly Process to Determine Whether or Not The Board has Actual Bias and Prejudice which prevent them from Acting as an Impartial Tribunal

BASS filed a motion for the Board to either recuse themselves and refer the matter to an impartial hearing body or to dismiss the proceedings against him (**Exhibit 2**) as there was no written procedure set forth by the Board to address that issue. On the same day the motion was received by the Board, they summarily denied the same (**Exhibit 3**) without opposition being filed and without a hearing being afforded Petitioner. NRS 1.235 provides a procedure for the disqualification of judges other than Supreme Court Justices. That statute requires that once an allegation of bias and prejudice is made, the matter is to be immediately referred to another judge for hearing on the question of disqualification and the original judge hears the matter no further until that determination is made. The Board here simply determined that they had no bias or prejudice. Their decision made summarily without hearing and without referring the question to an independent body again reflects the need for adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings.

Petitioner contends that this Board has in the past and continues to demonstrate actual bias and prejudice toward him and his counsel and is not capable of providing him a fair hearing. The Hearing's Officer is under the direct control of the Board which limits his

powers to suit individual cases and therefore is necessarily an extension of the Board itself.

The following acts or omissions demonstrate this bias and prejudice:

(a) Denial of BASS of rights afforded other practitioners (discovery and peer review.) BASS has in this action been denied access to any discovery at all despite the fact that there is an unwritten "open-file" policy for all other practitioners. In fact, BASS in an earlier proceeding before this Board was himself provided with discovery pursuant to this "open-file" policy. However, in this more serious proceeding the Board is taking the position they don't have to provide him any discovery at all.(See Sorenson Affidavit.) The Board has further through its Hearing's Officer denied BASS the right to adequately prepare a defense by not provide him any of the evidence they intend to present against him or identity of any witnesses they plan to call against him. They have not informed BASS of the anticipated length of the hearing. They have refused to grant a continuance to BASS despite being informed of a death and resulting medical considerations in BASS' counsel's family. Their Hearings Officer has failed to respond to BASS' request to simply issue blank subpoenas in this matter forcing BASS to rely on the "kindness of strangers" in

compelling attendance to a hearing that holds his professional life in the balance. The Hearing's Officer further denied BASS' request to grant a change of venue.

(b) The Board has previously in earlier proceedings refused to permit BASS' counsel to present argument and evidence in support of important motions and in fact walked out en masse on Bass and his counsel. (December 2, 1988)

(c) The Board in prior proceedings involving Dr. Bass refused to disqualify a Hearing's Officer who made a prejudgment against Dr. Bass.

(d) The Board made a finding against Dr. Bass in a prior proceeding that he lacked credibility and good faith, which finding was not based upon credible evidence.

(e) The Board's hearing's officer in a prior proceeding concerning Dr. Bass permitted the Board's prosecutor to present evidence not previously disclosed pursuant to the Hearing's Officer's own Order and further permitted the introduction of evidence in contradiction of the rules.

(f) A Board member at a hearing in the prior proceedings insulted both Dr. Bass and his counsel by questioning Dr. Bass' counsel's representation of Dr. Bass.

(g) That the Board's conduct in prior proceedings has been such that counsel for Dr. Bass has been compelled to criticize their actions on numerous occasions. In the prior proceedings (which we have referred to herein) the Board determined that it had the authority to publicly reprimand Dr. Bass for intentionally misleading the Board concerning the status of his medical license and hospital privileges on a renewal application form. Bass advised the Board (after it had filed a public complaint against him--not affording him the opportunity to explain the same to them prior thereto as required by NRS 233B.127) that the source of their information was in error. The Board's source of information subsequently admitted their error and corrected the same. Even though BASS' response on the renewal application was correct in all regards, the Board rendered a finding that Dr. Bass intentionally misled them when he provided correct information.

BASS believes that the record more than adequately demonstrates the actual bias and prejudice of the Board against him. The touchstone of all of our judicial process in the United States is a **fair trial** in a **fair tribunal**. That's all BASS is asking. In Withrow v. Larkin, 421 U.S. 35, 46, 95 S.Ct. 1456, 1464 (1976), the Court stated as follows:

"Concededly, a 'fair trial in a fair tribunal is a basic requirement of due process.' *In re Murchinson*, 349 U.S.133, 136, 75 S.Ct. 623, 625, 99 L.Ed. 952 (1955). This applies to administrative agencies which adjudicate as well as to courts. *Gibson v. Berryhill*, 411 U.S. 564, 93 S.Ct. 1689, 1698, 36 L.Ed.2d 488 (1973). Not only is a biased decisionmaker constitutionally unacceptable but '**our system of law has always endeavored to prevent event the possibility of unfairness**.' *In re Murchinson*, supra, 349 U.S.at 136, 75 S.Ct. at 625; *cf Turney v. Ohio*, 273 U.W. 510, 532, 47 S.Ct. 437, 444, 71 L.Ed. 749 (1927). In pursuit of this end, various situations have been identified in which **experience teaches that the probability of actual bias on the part of the judge or decisionmaker is too high to be constitutionally tolerable**."(emphasis supplied)

16A AmJur 2d § 855, *Constitutional Law* (page 1076) states in part:

"Cases in which the adjudicator has a pecuniary interest in the outcome or in which he has been the target of personal abuse or criticism from the party before him have been said to be situations where the probability of actual bias on the part of the judge or decisionmaker is too high to be constitutionally tolerable under due process of law."

At the present time there is no orderly process in place to fairly adjudicate allegations of bias and prejudice and there should further be a procedure in place to provide a subsequent hearing body so the cloud over petitioner's head

can be cleared with due process. In view of the bias demonstrated by the Board, any further proceedings against Dr. Bass must be stayed at leased pending a determination in this case of the bias and prejudice. The reviewing Court with regard to Dr. Bass' Petition for Judicial Review refused to stay these proceedings and made an initial finding that no bias existed even though Petitioner was not afforded the right to present points and authorities and have a hearing concerning the same as provided by NRS 233B.130 and 233B.133.

III.

The Board Must Establish Uniform Rules Concerning Venue

The Board's policy concerning venue has been unwritten and arbitrary. For example, in the earlier proceedings, the Board denied change of venue, the Hearing's Officer (after a District Judge was reviewing the matter) granted the change of venue to Las Vegas and then (before the hearing) sua sponte changed the venue back to Reno. The Board has over the objection of BASS set the matter in Reno despite having appointed Hearing's Officers in place in Las Vegas, despite Board meetings being held in Las Vegas, despite the majority of the Board being in Las Vegas, despite having attorney generals in Las Vegas, despite Bass and his counsel having their offices in Las Vegas, despite the alleged incidents complained of occurring in Las Vegas, and despite the majority of the witnesses being in Las Vegas. The only reason for this denial is for punitive purposes and to make it impossible for Dr. Bass to defend himself because of economic and logistical hindrances. The actions of the Board have already caused Dr. Bass

severe economic hardship requiring him to seek Bankruptcy Court protection.

The reviewing judge did order the Board to change the venue to Las Vegas or pay travel expenses for Bass, his counsel and witnesses. This relief is not adequate as Bass, his counsel and witnesses would sustain far greater losses in traveling from Las Vegas to Reno than just travel expenses. Both BASS and counsel have their businesses in Las Vegas and the Board has refused to provide BASS the discovery they provide all other practitioners which will necessarily require a very lengthy hearing as discovery will have to be conducted during the hearing. The custodians of records are in Las Vegas--not Reno and there is no written hearing procedure so BASS doesn't know how long he would be afforded (if afforded any time at all) to obtain rebuttal witnesses which would most likely be in Las Vegas. BASS does not know who the Board will call as witnesses. At the present time, BASS is not even sure where this hearing will be.

The Board's unwritten special rules in regard to venue violates Article IV, § 20 of the Nevada Constitution which states in part as follows:

> The legislature shall **not pass local or special laws in any of the following enumerated cases**--that is to say:. . .**Providing for changing the venue in civil and criminal cases.**
> (emphasis provided)

State of Nevada v. Con. V.M. Co., 16 Nev. 432 (1882) stated in part as follows:

"Because the whole act of which section 2 is but a part is invalid, for the reason that it is a special law for the collection of taxes, which is prohibited by section 20 of article IV of our constitution. **It is special because it relates to particular suits only. It has no general application; it is not a rule of conduct or principle for the government of the people; it has no prospective operation. . . .**" (emphasis provided)

IV.

Irreparable Harm Will Result if the Board is Permitted to Conduct a Hearing against Petitioner that Deprives him of Due Process of Law

It is clear that the Board will go forward with its hearing against Petitioner without adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings if they are not prohibited from doing so by this Court. It is further clear that the Board will go forward with its hearing without providing Petitioner even minimal discovery, without identifying its witnesses and without permitting procedures which would allow Petitioner to adequately prepare for the hearing and defend himself if not prohibited in doing so by the Court. It is further clear that the Board will go forward with the hearing despite its actual bias and prejudice against this petitioner unless prohibited to do so by this Court. It is additionally clear that the Board will continue to make its own special unwritten rules

concerning venue unless prohibited to do so by this Court. There is just no plain, adequate or speedy remedy at law to correct the problems referred to herein. What is at stake is petitioner's valuable property of his right to practice medicine. NRS 630.356 provides that if the Board limits, suspends or revokes Petitioner's license to practice medicine in any way, he cannot be granted a stay by the Court pending any further review by the Court. If this occurs, even if he was ultimately successful, his professional career would be in ruin. The publicity associated with an adverse finding creates irreparable harm which is well understood by the Board and has to be a major consideration in evaluating the fairness of these administrative type hearings.

CONCLUSION

Neither the Board nor its Hearings Officers have the power to conduct hearings without the adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedures for the conduct of disciplinary hearings as this amounts to nothing other than denial of due process of law. Neither the Board nor its Hearings Officers should be permitted to proceed when charges of actual bias or prejudice have been brought. Neither the Board nor its Hearings Officers should be permitted to proceed when actual bias or prejudice have been established. Neither the Board nor its Hearings Offers should be permitted to establish special unwritten rules concerning venue. Neither the Board nor its Hearings Officers should be permitted to deprive the petitioner of rights it affords concerning discovery which it provides to other practitioners. Neither the Board nor its

Hearings Officers should be permitted to deny petitioner the rights it affords other practitioners. Therefore, the issuance of a Writ of Prohibition or an alternative writ of mandate is warranted and indeed necessary in this situation to prevent irreparable harm from occurring to Petitioner, herein,

WHEREFORE, Petitioner prays that the following relief be granted him:

1. That this Court issue a mandate for the Board and its Hearings Officers to stay all proceedings in Case No. 9455 pending the adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minimal due process procedural requirements for the conduct of disciplinary hearings including:

(i) sufficient time notice of a hearing to enable an accused to adequately prepare for hearing with due regard for the complexity of the issues, witnesses and evidence, i.e., not less than 30 days together with provisions for continuances which may be granted for good cause.

(ii) procedures allowing for discovery of witnesses and evidence upon which the Board may rely at the hearing.

(iii) procedures for the taking of depositions or discovery of the opinions of witnesses whose opinions may be relied upon at the hearing.

(iv) time allowed for the hearing with due regard for the rights of all parties to present witnesses and evidence..

2. That this Court issue a mandate for the Board and its Hearings Officers to stay all proceedings in Case No. 9455 pending the adoption of written rules and regulations establishing a procedure for determination of place of venue.

3. That this Court issue a mandate for the Board and its Hearings Officers to stay all proceedings pending the adoption of rules governing procedures for alleging bias against the Board.

4. That this Court issue a mandate for the Board and its Hearings Officers to provide Dr. Bass with all of the same procedures and remedies provided other physicians.

5. That this Court issue an order prohibiting the Board and its Hearings Officers from proceedings with its disciplinary action against BASS prior to the adoption of written rules of practice as provided by NRS 233B.050(1)(a) establishing minor due process procedures for the conduct of disciplinary hearings.

Respectfully submitted,
/s/ R. Paul Sorenson
R. PAUL SORENSON
Nevada Bar No. 002124
513 South Sixth Street
Las Vegas, Nevada 89101
Attorney for Petitioner,
HARRISTON LEE BASS, JR.

STATE OF NEVADA)
)ss:
COUNTY OF CLARK)

HARRISTON LEE BASS, JR., M.D., upon being first duly sworn, deposes and says:

That I am the Petitioner in the above entitled action; that I have read the above and foregoing PETITION FOR ISSUANCE OF WRIT OF PROHIBITION AND/OR FOR AN ALTERNATIVE WRIT OF MANDATE and am familiar with the contents thereof; that the same is true to my best knowledge, except to those matters stated upon information and belief, and as to those matters, I believe them to be true.

/s/ Harriston Lee Bass, M.D.
HARRISTON LEE BASS, JR., M.D.

SUBSCRIBED and SWORN to before me this 3rd day of September, 1992.

/s/ Sarah S. Higgins
NOTARY PUBLIC in and for said County and State

NOTARY PUBLIC
STATE OF NEVADA
County of Clark
Sarah S. Higgins
My Appointment Expires May 11, 1996.

AFFIDAVIT OF R. PAUL SORENSON

STATE OF NEVADA)
)ss:
COUNTY OF CLARK)

R. PAUL SORENSON, upon being first duly sworn, deposes and says:

1. That I am the attorney for Petitioner, Harriston Lee Bass, Jr, M.D. and have been his attorney since approximately December, 1987 and have represented him since that time in proceedings before the Nevada State Board of Medical Examiners and have personal knowledge of the acts and practices of the Board as they relate to Dr. Bass.

2. That based upon my observations, I am of the opinion that the Board has displayed bias and prejudice against Dr. Bass and myself and that a hearing in front of an independent body is necessary to fairly consider these allegations.

3. That some of the acts of bias and prejudice of the Board of which I am personally aware are as follows:

a. The arbitrary setting of venue in Reno when it serves no purpose other than to punish Dr. Bass with additional expenses and limits his ability to set forth a defense. This is particularly apparent since all of the alleged acts of malpractice occurred in Las Vegas where all witnesses reside.

b. That the Board has deprived Dr. Bass of peer review in both proceedings they have had against him, yet provide this peer review to other practitioners.

c. Discovery through the Board's unwritten "open-file" policy has been denied Dr. Bass in these proceedings wherein there is an allegation of gross-malpractice against him in spite of the fact that the Board regularly provides this open-file discovery to all other practitioners which I am aware of due to my prior experience before the Board in other proceedings. That this deprivation gives Dr. Bass no ability to defend himself and gives affiant no opportunity to prepare an adequate defense for Dr. Bass in any orderly or economic manner. That the Board prohibits prehearing depositions and has previously pointed to its "open-file" discovery process as giving practitioners adequate due process of law.

d. That the Board heretofore made a finding against Dr. Bass that the intentionally misled them and lacked credibility or good faith. These findings were based upon Dr. Bass' inability to foresee a mistake that was made by the party supplying information to the Board. The supplier of the information has since corrected the record. All of those records are subject to the Privacy Act. An impartial review of all of those records that were generated would establish that Dr. Bass was the subject of either or both racial or professional prejudice.

e. Members of the Board and the Board as a whole have insulted both Dr. Bass and his counsel requiring counsel to respond with strong criticism. This would include the Board refusing to allow Dr. Bass's counsel to make any presentations concerning motions and in fact walked out en masse on Dr. Bass and his counsel at a meeting they had been invited to on December 2, 1988. A Board member further directed derogatory comments to affiant at a hearing on June 7, 1991:

> "MR. SORENSON: The reason I was suggesting this is I consider the matter serious, as I know you do. I would like the opportunity to make appropriate objections concerning each and every Finding of Fact that's made here, so that a court when reviewing this matter can do it intelligently, and we don't have to go through some of the stuff that we've been through today. Thank you.
>
> MS. EBNER: Have you asked Dr. Bass if he wants to go through with all that?
>
> MR. SORENSON: I think that's between my attorney--his attorney and himself. And I consider that to be an inappropriate comment, and I

would suggest you apologize to Dr. Bass and to me.

MS. EBNER: I apologize.

MR. SORENSON: And maybe there should be some reprimand to you for doing that. Shame on you."

(Transcript before the Board, 6-7-91-pages 65-66)

As can be seen from the above, affiant was compelled to take exception with the Board member's conduct in trying to in my view interfere with Dr. Bass' exercising his right and duty to protect his professional reputation.

4. That irrespective of the fact that there was a death in affiant's family and being advised of the medical reasons and personal reasons for requesting a continuance, the Board opposed the same and through its Hearing's Officer arbitrarily denied the same without hearing.

5. That I am aware that even the rules of procedure provided in Chapter 640 of the Nevada Administrative Act for physical therapists provide more safeguards than the Board does in writing .

6. That I am aware that the State of California provides

extensive rules and regulations governing the conduct of disciplinary proceedings.

/s/ R. Paul Sorenson
R. PAUL SORENSON

SUBSCRIBED and SWORN to before me
this 3rd day of September, 1992.

/s/ Rita Hanache
NOTARY PUBLIC in and for said
County and State

NOTARY PUBLIC
STATE OF NEVADA
County of Clark
Rita Hanache
My Appointment Expires April 10, 1998.

UNIVERSITY OF NEVADA SCHOOL OF MEDICINE
DEPARTMENT OF SURGERY
1000 Locust Street
Reno, Nevada 89120
Received Sept. 10, 1991
Nevada State Board of Medical Examiners
Board Exhibit 3
Case No. 9455

September 9, 1991

Patricia R. Perry
Executive Director
Nevada State Board of Medical Examiners
1105 Terminal Way, Suite 301
Reno, NV 89510

Re: BME Case Number 9010028

Dear Ms. Perry:

I have had the opportunity to review all of the provided records involving the unfortunate hospital course and subsequent death of Violet Blanchard. I understand that my specific focus in that review was to determine whether either of the Board's definitions of "malpractice" or "gross malpractice" might apply to the care provided by Harrison L. Bass, Jr., M.D., in the discharge of his duties on Ms. Blanchard's behalf.

The case presents a compounding sequence of surgical complications resulting the ultimate complication of the premature death of the patient. In retrospect, it would be ease to question the judgement implied by proceeding with laparoscopic surgery in a densely adhesed

abdomen, the surgical technique that would lead to multiple, unrecognized bowel lacerations, and the ethics involved in the hasty patient transfer to other physicians and hospitals prior to a trip to Orlando. I am also impressed by the completeness of documents labeled "office notes which were submitted as documentation of care, and would be curious to see if the office notes of all patients are as complete. However, I find no documentation to support my malevolent suspicions nor do I, in these photocopied documents, find any evidence of the falsifications or deceptions that have apparently been alleged.

I feel naggingly as though I have not performed the duties that were my charge. I certainly encourage and endorse the Board's activities and attempts to ferret out practitioners of malpractice and bring them to discipline. But surgical disasters befall all of us and those poor outcomes alone are not enough to imply breach of performance. Indeed, from the evidence provided, I could as easily argue in favor of Dr. Bass' performance as against it.

If the Board is able to locate a smoking gun such as a statement by the surgeon accepting transfer (Dr. Choudhury) that misrepresentation was made, or if the original documents somehow are able to demonstrate tampering that these photocopies do not, then my position might be very different. Lacking that type of damning evidence, I found no justification for discipline or censure.

Thank you for the opportunity to participate in the Board's important work.

Sincerely
/s/ Byron McGregor, M.D.
Byron McGregor, M.D.
mm

SURG.

ADMISSION SLIP **ICU/IMC**

21989892

Admission Date **8/27** Admission Time_____ Room#**001-4**

Smoker___Orders_____

Patient**Tryon, William** Age/Sex**58/M**

Phone #_____

SS#_____ DOB**7-29-34** Employer_____

Diagnosis **acute pulmonary edema/surg ABD**

Procedure **Bowel obstruction**

Admitting Physician **Dr. Bass Follmer** Phone_____

Resident Physician **Lenhart**

Pay Source **Mutual of Omaha S/P**

Authorization#_____

Source of Admit:ER/QC#_____

OP Service_____ OP Service_____ Other_____

Transfer Form_____Scheduled **Beeper 222-6626** Date/Time **8/27 Dmm 0905**

Comments:**Womens hosp. acute care**

****

Financial Screening by:_____**3 days**_____

Date/Time_____

Pre-Admitted by_____Date/Time_____

****

Denied per David Brandsness/E. Hill R.N.

per Jackie Taylor

Sat - hernia repair - Monday
Mon to Women's - poss. acute abd. dstr. vs. necrotic bowel

WBC 13.2,	**15.8/42**	**Bun**	**40**
Creat	**1.9 (2.5)**	**lytes**	**OK**
T 98.3	**140/80**	**P**	**113**
NGT	**1045/24°**		
IV lasix,	**resp. distress - C.H.F.**		
2mc (E.R.)			
?G(-) sepsis	**ABG - 8/27**	**0830**	**7.32**
CSI	**0255 HCO325.5**		
B.E.-.7	**85.2 sat**	**02**	**6L/NC.**

***All bolded entries were hand-written on original document.**

****Entries that contain strike-thru notations were stricken thru on original document**

BEFORE THE NEVADA BOARD OF MEDICAL EXAMINERS

Case No. 9455

In the Matter of the Complaint)
Against:)
HARRISTON LEE BASS, JR., M.D.,)
Respondent.)
)

AFFIDAVIT OF CRAIG A. VOSS, M.D.

STATE OF NEVADA)
) ss:
COUNTY OF CLARK)

CRAIG A. VOSS, M.D., upon being first duly sworn, deposes and says:

1. That I am a licensed physician practicing in the State of Nevada and make this affidavit upon my best knowledge, information and belief.

2. That attached hereto as **EXHIBIT A** is a copy of a Report that was prepared by myself on August 27, 1992 concerning William E. Tryon.

3. That copy of the report is a true and correct copy of the original filed with University Medical Center.

4. That today, August 22, 1996 is the first time that I have talked with anyone concerning this patient. On this date I spoke with Dr. Bass' counsel R. Paul Sorenson and Michael V. Stuhff. That at no time prior to today has anyone from the Board of Medical Examiners contacted me with regard to this patient.

5. That the tissue which I examined is consistent with a complete volvulus that occurred approximately six hours before the

recovery of such tissue.

6. That it is reasonable from the examination of the condition of the tissue that it was the result of a sudden, complete volvulous.

/s/ Craig A. Voss
CRAIG A. VOSS, M.D.

SUBSCRIBED and SWORN to before me this 22nd day of August, 1996
/s/ Sarah S. Higgins
NOTARY PUBLIC in and for said County and State

DISTRICT COURT
CLARK COUNTY, NEVADA
Filed January 18, 1995
Case Nos. A 328764 and 329186
Consolidated in Dept. No. XII

HARRISTON LEE BASS, JR., M.D.,)
Petitioner,)
vs.)
BOARD OF MEDICAL EXAMINERS)
OF THE STATE OF NEVADA;)
)

HARRISTON LEE BASS, JR., M.D.,)
Petitioner,)
vs.)
BOARD OF MEDICAL EXAMINERS OF)
THE STATE OF NEVADA, et. al.,)
Respondents.)
)

EXCERPT OF
REPORTER'S TRANSCRIPT OF PROCEEDINGS
TUESDAY, January 10, 1995
Before the Hon. Myron E. Leavitt, District Judge

THE COURT:

Okay. This is a motion for Rehearing or to alter or amend the order remanding the matter, and motion for Court to issue instructions re the amended order, and motion to compel the board to permit inspection and copying.

. . . .

THE COURT

Well, again, I have your statement to the effect that's what the board is doing. The State is responding that's not what the board is doing, so there has to be hearing in front of the board. You have to make the request for theses things,

and if they refused to do it, at least we have a record that we can look at.

MR. SORENSON

I've already done it. This motion has been made so many times. I'm saying to you how many times do I have to ask the board? Let Miss Underwood tell you how many times I've asked for the board's records. If it's been one time, it's a hundred. I said you're not being faire. It's arbitrary and capricious. How can I be expected to defend this man without complete records?

The first order you issued, produce the complete records. The records that we got produced, your Honor, we know are not complete. It doesn't take a rocket scientist to figure that out. It takes time. As we get one document, the document we got yesterday gave us the names of five additional witnesses. Right now, to you the time that we have to put in to produce to the board, 26 witnesses they struck down on me, plus another 5. 31 without any subpoena power. 31 people are involved in this scandal. We're not talking about - two people died because of rotten records, deception, fraud, corruption. That's what's going on, and the board is protecting them. Why would they not give me the records other than to protect the people who are involved? There's no reason.

Now, the other part of my motion was for sufficient time, and they've conceded that.

THE COURT

They've conceded that so--

MR. SORENSON

Yeah. Okay. Here are the peer review records that we need at this point in time that my records tell me we do not have them as material evidence. With regard to Desert

Springs, we have testimony during the course of the hearing that members of the administration at Desert Springs introduced themselves to Dr. Bass' client and got them to sign a document that took him off the case. That's never been produced.

There's a letter that's referred with specificity from Desert Springs, a letter from Dr. Choudhury to Dr. Baranoff on August 6, 1990 that has to do with Patient A, never been produced. Executive committee meetings of August 10, September 5th, October 3rd, 1990 have never been produced, all having to do with Patient A. Surgery committee, August 14, 1990, having to do with the patient. It has in that particular meeting the testimony of Dr. Choudhury . We at least ought to get Dr. Choudhury's testimony and what other evidence you've already ordered them to produce it. They produced nothing.

We ought to have --these were complex operations, your Honor. They ought to have been reviewed by records committee. They are obligated by the standards to have them reviewed, which would tell us the source of some of the destroyed records.

Tissue committee. We all know the importance of tissue in operations. Those are gone. Pathology are disappeared. Now, that's just from one hospital on one Patient A.

I think Dr. Bass is entitled to have all the records, and these are the records - - any peer review that has to do with the complexities associated with this case because we don't know where the records went. We know they're missing, but we're not omniscient. We can't find them without your help.

You issued a specific with regard to one, and because I knew there has to be an admission slip at UMC, we got it. We got that record. But they're stonewalling us on all the other peer review stuff that had to occur.

If you look at Patient B and what happened to Patient B immediately after they interfered with his care and stopped him from operating on this patient, the patient got terminally ill because they delayed the operation for some five hours. That's a serious allegation. That's in the records. Dr. Bass called for an admission board certified surgeon to University Medical Center, had the patient admitted, and then has it interfered with by--the head administrator stopped the operation, let the patient lay with a cecal volvulus, the volvulus was 720-degree twist at the mesentery. no blood supply for five hours to the bowel. The bowel died, just like your arm, your leg, or anything else that lacked blood supply for five hours.

They're hiding these records, Judge, and they know they're hiding them. Now, who are they protecting? I don't know, but they're not protecting Dr. Bass. That I absolutely guarantee you. Now, we need your help to get those records, and what are we going to end up having? We'll end up having a fair hearing. We need them. I want the Court's rulings with regard to those things. Let me have the records and not have to spend any more obscene time. I am almost at the end of my money to be able to defend this man.

THE COURT: Miss Underwood.

MS. UNDERWOOD

Your Honor, as I've stated before, the board of medical examiners has never destroyed any records. We have no records in our

possession at this point that aren't part of the administrative record on appeal. I don't know what records Mr. Sorenson is talking about that we're hiding from him. The peer review records from any of the hospitals are totally irrelevant to this case, and every single one--

THE COURT

Well, the peer review records are confidential.

MS. UNDERWOOD.

Confidential by statute and irrelevant. Every single one of the medical experts, if we could ever get to the merit of this case, testified that the gross malpractice by Dr. Bass with respect to both Patients A and B occurred before the patients even arrived at the hospital, before the care was ever transferred to any of the other doctors. So what happened after the patients were transferred really doesn't matter.

THE COURT

Well, under the other case, of course, if you, in fact, destroyed or if you have destroyed records or are hiding records that might be of benefit to the doctor - -

MS. UNDERWOOD

We certainly have none. That is what I'm saying, and I guess I was addressing Mr. Sorenson's repeated request for peer review records.

THE COURT

Right. Well, the peer review records, of course, under NRS 49.265 are confidential, but what bothers me more than that is that he - - I understand it's just an allegation that you're destroying records and not letting him see the records that he needs in order to properly defend the doctor in front of the board. If, in fact, it later turns out, of course, that the board did

destroy these records or didn't consider these records that might be of benefit to the doctor, any action by the board will be thrown out. So I wouldn't see why the board - - give him anything he needed to defend.

MS. UNDERWOOD

I attached a copy of the transcript where Larry Lesley, the prosecutor, stated under oath that what happened with the records with regard to the board's medical expert was that a copy of the patient records went to Dr. Juell. He reviewed them. He made notes. He formed his opinion. The board of medical examiners then picked up those patient records and ordered a clean certified copy to be used as an exhibit.

THE COURT

And the reason it was destroyed is because he made notes on it, but another certified copy of the same exact records that wee destroyed was furnished to the board. Is that true?

MS. UNDERWOOD

That's correct, and is now part of the record on appeal.

THE COURT

All right. Mr. Sorenson.

MR. SORENSON

Your Honor, I think I'm entitled to know the person or persons who authorized those destructions. Your Honor, I don't care whether the notes - - one of the integral parts of this whole case that you understand, as I over look it, because I made this motion so man times, is the fact so this Court understands that the peer review that's conducted by this board is a farce with regard to Dr. Bass.

Let me tell you what they do in the ordinary, 99.9 percent of the cases that are

brought against doctors that are taken care of in, the, quote, peer review So the most important part of Dr. Bass' procedural rights we'll never know about because he wasn't invited to participate in the peer review. That was conducted by the board.

Now, the only - - the board taking -- the peer reviewer who has reviewed the records which is the basis behind why Dr. Bass has to be chastised in public have been destroyed by the board so the - - they claim they have to have prima facia [sic] case or reasonable cause to bring these actions. They've destroyed the basic information. That's equally as bad. Your Honor, stop and think of it. Isn't Dr. Bass entitled to the same privileges, same rights as every other doctor in this state? That's namely to get a fair peer review.

THE COURT

Well, I know, but your argument is not with me. Your argument is with the state legislature that made the peer review confidential.

MR. SORENSON

Your Honor, I don't want to interrupt you, and I apologize for doing it. There is nothing in the statue with regard to peer review. There are no rules and regulations concerning peer review. This is an invention of the board. They give wide variety - - I'm knowledgeable about what they gave, and I know as a practical matter that the good-old-boy system works well for some people, and they run the railroad the way they want to run it.

The thing that they have violated, your Honor - - and I have raised this so many times it causes the hair on my back to bristle when I say it. They are - - the only thing they are required

to do by the State legislature is to make pronouncements, make rules and regulations concerning every - - not just one, ever procedure that's available to the doctor in these types of cases. They have done none. That's the fact.

THE COURT

If I recall, according to my order, it was to the effect that you could look at the same material that the peer review committee looked at but you couldn't have a transcript of their hearing. Wasn't that the ruling I made.

MR. SORENSON

Your Honor, I would be happy - - I'm happy with your order, but I'm saying I'm getting nothing. They're saying it's all confidential. I've got nada from any one of the hospitals. Now, the fact of the matter is yesterday Women's Hospital produced one document under another court's order.

THE COURT

Well, what about that, Mrs. Underwood, regarding the order that I made that he could look at the same material that the peer review looked at?

MS. UNDERWOOD

That's correct.

THE COURT

Have you furnished him with that material.

MS. UNDERWOOD

Except with respect to the records at UMC, he has an entire copy of the medical records - -

THE COURT

That the peer review committee looked at?

MS. UNDERWOOD

Correct.

MR. SORENSON

Judge, okay - -

THE COURT

You're saying they're hiding it and destroyed it, but that's just an allegation.

MR. SORENSON

But they've admitted to destroying it.

THE COURT

Well, that's not quire what I read their brief to be. In other words, the brief indicated that certain records were destroyed because the doctor had made notes on them, the investigator.

MR. SORENSON

They gave these records to five or six doctors, so let me - - so the Court understands, they either gave the original set that they got, the same set to five or six doctors, or they made photocopies. Now, they also sent to those doctors transmittal letters explaining to the doctors what they were supposed to do. Now mysteriously, Judge, the transmittal letters, the records, the notes of all the doctors' have been destroyed.

THE COURT

Well, it's pretty clear in the Mishler case, and I note that Miss Underwood was the attorney in that case, the failure to marshal and preserve evidence with respect to license revocation proceedings warrants the charges against the doctor. That's what that case held. So if it turns out what you're telling me is true, then it would have to be dismissed. But at this point all I have is your statement t that you're doing it and her statement to the effect they're not doing it.

MR.SORENSON

—Your Honor, if you want to continue this for two days, I'll bring in the document with regard to it.

THE COURT

That has to be done in front of the board, not this Court. All I do is review the record to see whether or not that's true.

MR. SORENSON

Your Honor, only thing I'm asking - - I think I know the Court knows what I'm trying to achieve here. I'm going to find out what records they destroyed one way or the other. There's so many ways to do it. It just takes more time. I've asked the Court for the order. If the Court issues an order with specificity that they produce for the records that they obtained or a list of the records they originally obtained, if they destroyed them, when they destroyed them, I think Dr. Bass is entitled to them.

THE COURT

She's indicated in the brief there were no records destroyed.

MS. UNDERWOOD

That's correct.

MR. SORENSON

The records originally obtained and sent to the doctors with the doctors' notes concerning their review.

THE COURT

But they were replaced with a clear certified copy of the same records.

MR. SORENSON]

But I'm saying those doctors' notes are just as much evidence that Dr. Bass can and should be able to use because it has to do with the peer review.

THE COURT

You're going to have to examine the doctors that made the notes on the records.

MR. SORENSON

I did.

MS. UNDERWOOD

Which he did for three days.

MR. SORENSON

And I --

THE COURT

Before the board?

MS. UNDERWOOD

Before the board.

MR. SORENSON

Your Honor, I still don't believe that I've got an appropriate certification from the board as to whether they took the actions to destroy the notes of the doctor, the original records that they obtained, because I have absolute proof that the original records that were with the hospital have been either lost or destroyed. They have been replaced with other ones. Now, we know that.

THE COURT

If you can prove that, then under the Mishler case, if you can prove they've destroyed and failed to preserve the evidence pursuant to this license revocation proceeding, then it will be dismissed.

Michael Vaclav Stuhff, Esq.
513 South Sixth Street
Las Vegas, Nevada 89101
(702) 868-8820 (Voice/Fax, *Total Number*)

STATE OF NEVADA
BOARD OF MEDICAL EXAMINERS
1104 Terminal Way, Suite 301
Reno, Nevada

Re: BME v. Harriston Lee Bass, Jr., M.D.
Case No. 9455
Filed September 4, 1996
OFFERS OF PROOF

Violet Blanchard

1. All the doctors who testified or rendered opinions heretofore [**Dr. Juell; Dr. Gardner; Dr. Davidson; Dr. Carpenter, Dr. Pitts, Dr. Wilson and Dr. Dunkin**] were not aware at the time of their review of the medical records that the records they examined were not complete and had substantial omissions and in addition were not prepared in conformity with JCAHO standards. None were aware of the transfer records prepared by Bass re: Blanchard. None of them were aware of the Medical Diagnostics Services, Inc. team brought surreptitiously into the hospital which records were either never placed in or removed from the medical records of Womens Hospital. The diagnostic tests were performed by Medical Diagnostic Services at the instance of Dr. Plon into perform an Echocardiogram. No records or notes regarding such tests were entered in the chart in Women's Hospital in violation of JCAHO

or Nevada Administrative Code requirements or if records were entered they were subsequently removed from Women's Hospital and the records supplied to the Board of Medical Examiners.

Copies of these diagnostic test records were discovered fortuitously in the file Dr. Plon had in her automobile and brought pursuant to a subpoena duces tecum. Dr. Plon had neglected to remove the impeaching documents from her own file even though they had been removed from all other health care provider's records.

2. Admission history and physical provided to the B.M.E. and Dr. Bass was dictated on 12/12/90 and transcribed on 12/17/90 even though a Progress Note of 7/20/90 states that the History and Physical had been dictated some five months earlier. The earlier History and Physical is missing indicating it also had been removed from the record and re-dictated. The substituted History and Physical alleges that Dr. Plon's confederate, Dr. Choudhury saw the patient "immediately on admission". Dr. Choudhury attempted to support Dr. Plon and attempted to torpedo Dr. Bass but denied in his affidavit he had seen the patient on admission.

Dr. Bass submits the reason for Dr. Choudhury's denial of examination upon admission is his realization that if he admitted to having observed the patient at approximately 7:00 a.m. on 7/20/90 and if he also claimed later to have observed the serious complications of the sort he has indicated in his various reports he would have had to observe those complications in the morning. The easiest way to explain this inconsistency was to completely deny his earlier examination.

3. The Discharge Summary to the BME was prepared 13 months after the death of the patient and substituted for an earlier version, if a Discharge Summary had been prepared in a timely fashion. The substituted discharge summary alleges that Dr. Choudhury ". . . .found numerous bowel lacerations. . . ." which he excised. The Pathology Report indicates there were no lacerations visible to the eye or microscopically.

4. The altered, fabricated and substituted discharge summary prepared over a year later by Dr. Plon fails to mention or refer to her initial diagnosis of M.I. or cardiac arrest for which she obtained a surreptitious Echocardiogram from a private vendor who had to be brought into the hospital. The records of that Echocardiogram by M.D.S. were removed from the hospital records or in the alternative were never placed in the hospital records. The records of that Echocardiogram and the intervention by M.D.S. and its technicians were never documented or supplied to the BME nor to Dr. Bass. The existence of the records of M.D.S. were either removed or covered up by Dr. Plon were discovered fortuitously at her testimony before the BME on September 16, 1993. Dr. Plon, who had been subpoenaed to bring her records indicated she did not read or understand the duces tecum. However, she happened to have the records in her automobile. She had not taken the time to remove the records from her own files.

5. The sputum test ordered by Dr. Bass has been removed from the records. It is significant as it would have shown that the fluid in the lungs of the patient was caused by

aspiration of stomach acid during the placement of the C.V.P. line by Dr. Plon.

6. Dr. Plon's History and Physical [pages 9 and 10] refer to an abdominal C.T. scan performed on 7/20/90. The report is not in the records supplied to the B.M.E. The C.T. scan was not accomplished until many hours after the History and Physical should have been taken. A copy of that was also found later in Dr. Plon's records left in her automobile.

7. Dr. Plon's substituted admission History and Physical states that the patient demonstrated ". . . .poor ventilation showing high pulmonary pressures compatible with pulmonary edema." But the initial 7/20/90 progress notes were "CVP - 6: PCWP 8; C0-8: SVR not stated" The normals for these are CVP: 0-8: PCWP 4-12 and C 04-8.

The **observed readings are not high pulmonary pressures.**

8. A review of the records of Dr. Plon reflect there was a large number of medical records which were removed from both Desert Springs Hospital and Women's Hospital and not supplied to the BME or Dr. Bass.

9. There is partial documentation fabricated and remaining in the files for at least 5 false scenarios concerning the medical history of Violet Blanchard.

First False Scenario

A member of the Blanchard family testified that the doctors at Desert Springs Hospital advised them that their mother's bowel had been lacerated by misguided laser beams due to the negligence of Dr. Bass. [Laser was never used by Dr. Bass in her surgery.]

Second False Scenario

Dr. Golam Choudhury claimed to have observed necrotizing fascitis. No pathology report supports Dr. Choudhury. The testimony of Dr. Bierenbaum before the BME on September 15, 1993, who had examined Ms. Blanchard the day after Dr. Choudhury had said "I didn't see any necrotic fascia. . .the reason I put necrotizing fascitis in quotes in my initial note, I didn't see it and document it, and other people had said it was there. But I didn't see it." He also observed tellingly: "Looks like everybody's

notes went from the 24th to the 29th, Looks like you're missing some records."

Third False Scenario

Because other medical experts suggested that Dr. Choudhury should have utilized a colostomy if indeed the complications were present as he stated, an attempt was made to show that a colostomony was done. This attempted scenario was abandoned, however, there are billings for an ostomony bag and for ostomy training. This scenario was obviously abandoned because it would have involved bringing too many people into the conspiracy.

Fourth False Scenario

Dr. Choudhury claims in his progress notes to have examined a "loop of bowel" protruding above the skin outside of the abdominal cavity. Although such a procedure is rarely used in unusual circumstances where a bowel repair cannot be accomplished in an infected abdomen, no other health care provider or other individual ever corroborated the "disappearing bowel loop" scenario of Dr. Choudhury and he apparently abandoned the bowel loop theory.

Fifth False Scenario

The final false scenario is that Dr. Bass transferred a critically ill patient to other physicians and failed to advise them of the true condition of the patient. In support of this, Drs. Plon, Choudhury and other persons removed the transfer records of Dr. Bass; removed or failed to include in the hospital records the diagnostic echocardiogram; removed the original History and Physical; removed the original Discharge Summary; substituted a History and Physical; substituted a new Discharge Summary; removed the orders of Dr. Plon for that Echocardiogram;

removed the records of that Echocardiogram in an attempt to remove all records which would show the true condition of the patient for the 18 hours prior to and on transfer and leave to the reviewers only those records which would direct blame at Dr. Bass,

William Tryon

At the time that Dr. Bass operated on Mr. Tryon for a routine hernia repair at Womens Hospital, other actions by the BME and The Doctors Company (TDC) had been proceeding and the small group controlling the BME and TDC had found that he was uncooperative and to use a term that may be somewhat dated but appropriate to his struggles, a little "uppity." (The BME President and now "Chairman" stated that "Bass' problems was not so much a lack of skill but a lack of humility.")

Surgery accomplished by a team headed by Dr. Follmer confirmed that Mr. Tryon had complications resulting from a volvulus as his bowel twisted upon itself as the effects of the anesthetic wore off. The volvulus twisted 720 degrees (two complete turns) acutely cutting off the mesentery at its root. (The cecum was congenitally not anchored to the abdominal wall, allowing the double rotation) Dr. Bass, on 8-27-92 determined that Tryon needed critical care which could only be provided at a hospital with an intensive care unit, not available at Womens at the time. He arranged for Tryon's transfer to U.M.C. and arranged for his surgical team to meet and operate at U.M.C. at 9:05 a.m. Dr. Bass was refused the right to operate by the hospital administrator, Mr. Brandsness. Mr. Brandsness at first told Dr. Bass that he was going to "teach Womens hospital a lesson" because they were "taking the cream." (His

statements referred to his apparent belief that Womens was attempting what is referred to as a COBRA violation, "dumping" of a patient whose insurance coverage has been exhausted onto a public hospital to provide further services at public expense.) The record showing that Dr. Bass had arranged for the transfer was removed from the file. Those who wanted to eliminate Dr. Bass had thought that they would find that he had negligently perforated the bowel as they had previously claimed to have occurred in one of the false scenarios of the Blanchard case. They wanted another team to open Tryon up and find the proof which would finally ruin him. As a result, Tryon lingered in pain for five unnecessary hours until a replacement team came in the place of Dr. Bass as Tryon's physician and surgeon. When the replacement team, headed by Dr. Follmer opened Tryon up, they found not what had been expected by Dr. Bass' accusers, which was evidence of his negligence, they found instead the volvulus which had become necrotic (the tissue had actually died because of loss of blood circulation) during the five hour delay. Tryon survived and lingered through multiple surgeries before he eventually expired.

When the self-appointed "saviors" who had determined to find evidence of Bass' negligence realized what they had done, the cover-up swung into action immediately and completely. They had withheld from Tryon's survivor's that Mr. Tryon's death was due to the willful and malicious interference with his care by "professionals" who assumed arrogantly that they would find evidence of negligence by Bass which did not occur and instead they caused his

painful, expensive and lingering death by preventing his prompt and appropriate care.

Craig Voss, M.D. is the pathologist who examined the tissue excised by Dr. Follmer. Counsel for Dr. Bass, Paul Sorenson, was threatened by the BME with bar sanctions if he called Dr. Voss in prior hearings and was not permitted to examine him by deposition previously. Pursuant to the recent Order of Judge Leavitt, Dr. Voss was interviewed. He stated and provided an affidavit that no one to his knowledge from the BME or any of the other entities involved had previously contacted him or asked for his opinions. His affidavit sets forth his opinion that the tissue he examined was consistent with a complete volvulus which had occurred approximately 6 hours prior to its excision, consistent with Dr. Bass' observation.

Someone at UMC removed the critical ADMISSION SLIP prepared for Mr. Tryon along with its notations of Dr. Bass' plan for immediate abdominal surgery, and notations regarding test results and vital signs, and a damning notation that the Admission was "denied per David Brandsness" from the hospital medical records. Dr. Follmer, who had been recruited to head the surgical team which had been assembled to replace Bass, stated in his testimony before the BME that he had been contacted earlier in the day by Womens Hospital (Dr. Sheld) to help "get" Dr. Bass.

The Conflict of Interest

TDC's concept of a "team defense' has been to sacrifice one of the members of the team (Dr. Bass) and to protect supposed other members of the "team" with whom he shared no community of interest and to whom he was in fact adverse.

TDC has refused to pursue the issues of spoliation of evidence and fabrication of evidence by other parties to the action. Despite the demonstrable bad faith, fabrication and destruction of evidence by other parties to the action, TDC has followed a course of collaborating with those culpable parties in a "team defense" which is completely inappropriate when the other members of the so-called "team" have demonstrated that they have planned to set Dr. Bass up as the "fall guy" for the other health care providers aligned with The Doctors Company.

On August 22, 1996, the Deposition of the former Risk Manager for UMC at the time of the transfer, Mike McCallister, McCallister's testimony revealed and confirmed the extent and gravity of the conflict.

At the same time that TDC was paying attorney Jeff Ballin, then of the Alverson, Taylor firm to "represent" Dr. Bass in the Tryon lawsuit, UMC had retained and Mike McCallister was meeting with attorney Jeff Ballin **on the same matter** for the purpose of protecting UMC from liability. Ballin's firm sent a lengthy affidavit to Dr. Bass which Ballin explained needed to be executed "immediately" before the notary who was sent by the firm to witness the document. Buried in paragraph 74 of the complex text was a critical and untrue admission alleging that Bass was not on staff at the time of the incident. The false statement was calculated to clear UMC for refusing admission of Bass' patient and to submarine Dr. Bass' defense. Dr. Bass and his independent counsel were later told by Ballin's firm that the untrue information had come from Mike McCallister, an executive at UMC. After this crucial misinformation was questioned by

Bass and his independent counsel, Ballin's firm withdrew from Bass' defense citing that it had a conflict. **Ballin never revealed or acknowledged that he was actually being retained and paid by a hostile party which had hidden records and which was actually responsible for the delay causing Mr. Tryon's death.** Until McCallister's testimony, it had appeared that Ballin's contacts with McCallister had ostensibly been in Ballin's capacity as Bass' lawyer, not as the lawyer for UMC. Mike McCallister was apparently not aware, when he testified of the nature and gravity of his remarkable revelation which goes far in explaining why neither TDC nor the lawyers it has retained to provide a "defense" for Dr. Bass ever conducted an appropriate investigation in these or related proceedings.

Respectfully submitted,
/s/Michael V. Stuhff
Michael V. Stuhff
MVS:ssh

BLANCHARD'S FIVE FALSE SCENARIOS

Re: BME v. Harriston Lee Bass, Jr., M.D.
Case No. 9455
Filed September 4, 1996

FALSE SCENARIO #1 - MISGUIDED LASER BEAMS - BOWEL INJURIES

•ROBIN McCARTHY DEPOSITION 3/23/93 **Laser Beam burns** to bowel, p. 89, line 24 - p. 90, line 3 Dr. Choudhury giving the family Attorney Galatz' business card - p. 80, lines 1-4; p. 81, lines 19-22 & p. 89, lines 13-19
•Dr. Speck's consult - DSH p. 20
•Dr. Choudhury's consult - DSH p. 23
•Dr. Bierenbaum's consult - DSH p. 25
•Dr. Michael Gross' consult - DSH p. 28
•Dr. Steven Glyman - DSH p. 31
•Pathology Report, Howard Hoffman, 7/22/90. The pathology report reveals a normal sutured repaired bowel area with no findings of unrepaired laceration, pus or leaking bowel contents even under microscope

•Dr. Bierenbaum's testimony, 9/15/93 hearing, p. 42, lines 5-14

FALSE SCENARIO #2 - NECROTIZING FASCITIS

•Choudhury Pre-op & Post-op notes 7/21/90 DSH p. 132- 133
•Dr. Bierenbaum, plastic surgeon - no necrotizing fascitis observed, DSH p. 140 - written notes, DSH p. 25 - Consultation - no necrotizing fascitis observed
•Hearing 9/15/93 p. 42, lines 24-25 "**I could not make a diagnosis of necrotizing fascitis from what I saw there**" (On 7/21/90) p. 44, lines 15-23 "Dr. Choudhury did not point out necrotizing fascitisto me." p. 45, lines 1-3 "I didn't see any necrotic fascia
•No tissue to pathology to support necrotizing fascitis on 7-20-90
•Failed to document **management** of alleged abscesses.
•Alleged colon injury not documented by O. R. Nurse Karnowski 9/20/93 hearing, pp. 38-40

FALSE SCENARIO #3 - Colostomy

•Nursing notes at DSH p. 798
•Dr. Wilson Expert opinion 6/10/92, pg. 5, lines 20-24
•BME Hearing 9/93 Davidson p. 73, lines 21 & Juell p. 146, lines 21-23, p. 147, lines 9-10 & 20-21
•Bills for colostomy supplies and training left in patient records.
•No documentation attempted that colostomy operation was ever performed.

FALSE SCENARIO #4 - "Vanishing" Loop of Bowel

•Dr. Choudhury hand written note, p. 143
•No other health care provider claimed to have noticed loop of bowel protruding above the skin outside the belly.

FALSE SCENARIO #5 - Failure to Advise

•Bryon McGregor (9/9/91 letter used by others as guideline for later fabricated records and theory

". . . .I find no documentation to support my malevolent suspicions nor do I, in these photocopied documents, find any evidence of the falsifications or deceptions

that have apparently been alleged."

"I feel naggingly as though I have not performed the duties that were my charge."

"If the board is able to locate a smoking gun such as a statement by the surgeon accepting transfer (Dr. Choudhury) that misrepresentation was made. . . .then my position might be very different. Lacking that type of damning evidence, I found no justification for discipline or censure."

•SUBSTITUTED History & Physical OF DR. PLON dictated on 12/12/90 (Five months after admission) - DESERT SPRINGS HOSPITAL, p. 9 - **Dr. Golam Choudhury saw the patient immediately on admission** and ordered CT scan of the abdomen.

•Dr. Gardner affidavit p. 6 - "**On arrival at DSH, Dr. Choudhury found her to be septic** with a distended abdomen, acutely tender with rebound, no bowel sounds, bruised right flank with ecchymosis and edema and exquisitely tender."

•Substituted Discharge Summary of Dr. Plon dictated 9-11-91, **13 months after** patient's death and **2 days** after Dr. McGregor's opinion.

•**MDS echo cardiogram** results ordered under Dr. Bass' name although Dr. Bass was never informed of its existence and records of this diagnostic test were removed from all files except Dr. Plon's -- left in her car.

•Dr. Plon's consult at Women's Hospital on 7/19/96 **"Unfortunately we don't have the capabilities to put a Swan Ganz catheter here."** (to monitor the M.I. she initially suspected.)

•Dr. Bass' 7/20/90 **Transfer orders** to rule out Pneumonia, to keep bed head over 30 degrees of elevation to prevent aspiration, copies of X-Ray with patient to DSH and Dr. Choudhury was to cover for Dr. Bass until 10 p.m. on **7/22/90**.

•Dr. Bass' 7/20/90 4:30 a.m. order for **sputum test** which results were removed from hospital records.

•DSH nursing notes p. 798 on 7/21/90 purporting to document "Dr. Bass in Dsg (dressing) taken down and changed." Dr. Bass was in Florida at the time of the alleged observation.

•Orlando Heritage Inn bill documenting Dr. Bass in **Florida** until 7/22/90

•Dr. Speck, testimony, 7-14-93, ". . . .no records from Womens

Hospital at this point."

•Lab studies stating Dr. Plon's admitting diagnosis of "**Unstable Angina - Post M.I.** on 7/28/90.

•Plon, testimony 9/16/93 - "I don't see my notes here, and I don't know why."

•Dr. Tawney testimony 9-10-93, "I think chart is incomplete."

Dr. Tawney's dictated consult is missing.

•Dr. Juell testimony 7-7-93 "I can't find progress note. It's not in the records. . . .Maybe there's some missing records here."

•Dr. Speck testimony 7-14-93 "I would have quoted [those records if I had them]"

IN THE SUPREME COURT OF THE STATE OF NEVADA
Filed MAY 7, 1998
Case No. 30632

HARRISTON LEE BASS, JR., M.D.,	)
Appellant/Cross-Respondent,	)
vs.	)
STATE OF NEVADA, BOARD OF	)
MEDICAL EXAMINERS,	)
Respondent.	)

EXCERPT OF APPELLANT'S OPENING BRIEF

F. Review of Marina Plon, M.D.'s Treatment of Patient "A"

- 7-19-90 @ approx. 12 Noon saw Patient A. Observed that she was "in no acute distress".
- Testifies at the hearing that she didn't bring the records requested in Bass' subpoena - that they were at her office
[Appellant's Appendix Vol. II, p. 311]
- Later testifies that all the records on Patient "A" are in the trunk of her BMW [Appellant's Appendix Vol. II, p. 314]
- Original Discharge Summary **missing.**
- New Discharge Summary not dictated until 9-11-91 (page 3 missing--two days after BME receives McGregor report of no malpractice.)

• Dr. Plon's treatment of Patient "A" remains a partial mystery as the records of that care were substantially removed from the medical records at Women's Hospital and Desert Springs hospital. The following is a list of the deficiencies in the record that Dr. Bass has been able to uncover at this time. As indicated below, a few of these missing records were discovered from the records that were retrieved from the trunk of Dr. Plon's car:

Deficiencies in Patient A's Records in Dr. Plon's Women's Hospital Records

Date	Description	Deficiency
7/19/90	Progress Note--Handwritten Consult	***Missing***
7/19/90	Progress Note--Impression of CVP insertion after review of X-ray	***Missing***
7/19/90	Progress Note--Examination of patient supporting need for echocardiogram	***Missing***
7/19/90	Order for Echocardiogram	***Missing***
7/19/90	Nursing Note concerning	

Echocardiogram
Missing

7/19/90
Written Echocardiogram Report
Missing/found in Dr. Plon's BMW trunk

7/19/90
Progress Note - Doctor's Evaluation of Echocardiogram
Missing

7/19/90 Progress Note - Doctor's diagnosis of patient's problems after Echocardiogram
Missing

7/19/90 Progress Note - Doctor's Order concerning her diagnosis after Echocardiogram
Missing

Other Records Problems
Re: Patient A

Date	Description
7/20/90	Sputum test results ordered by Dr. Bass are **missing**
7/20/90	Original Transfer Order prepared by Dr. Bass as well as other original documentation of Women's Hospital not in Women's Hospital's certified records, but found in Desert Springs Hospital's records.
7/20/90	Testimony by all Consultants Choudhury, Tawney & Speck that Women's Hospital records were not available for their review prior to their consult
7/20/90	Numerous additional problems with regard to records in violation of JCAHO standards, Nevada law and hospital rules.

Deficiencies in Patient A's Records at Desert Springs Hospital

Ref.	Date	Description	Deficiency
	7/20/90	Original History &	***Missing***
	7/20/90	EKG on Admission	***Missing***
	7/20/90	Echo order & notation	***Missing***

7/20/90
Cardiac Enzymes (result & Order)
Missing

7/20/90
Transfer Records of Womens Hospitals and X-rays
Records altered

7/20/90 thru 8/3/90
Chest X-rays/Orders/Reports
Missing

7/20/90
CT scan and report of Abdomen & Pelvis
Missing

128 7/20/90
SVR Reading Plon's new admission note
Missing

7/20/90
Operating Room and Anesthesia official records of claimed leaks and repairs
Not consistent with Dr, Choudhury's report.

7/20/90
Tissue Report Concerning Operation of Choudhury
Missing

7/20/90 to Death of Patient
Physical exam of the patient
90% Missing

7/20/90
Diagnoses of patient
Missing

7/20/90
Photos
Missing from certified records, not examined or commented on by BME reviewers

Original Discharge Summary
Missing

9/11/91
New Discharge Summary
Missing pg. 3

Numerous entries in the records show there were attempts to change the records of Patient A to reflect 5 separate and distinct false scenarios. (See Exhibit submitted to BME at Remand hearing entitled "Patient A - 5 False Scenarios")

G. Review of BME's "Investigation" and Conduct Concerning Patient "A" and Proceedings it Instituted against Dr. Bass

1. BME commenced its investigation of Dr. Bass on the basis a **letter from Dr. Berliner of Desert Springs Hospital dated 10/16/90.** This letter reflects the following false facts

- Plon transferred the patient immediately after she saw her.

- Plon or somebody at DSH spoke with Dr. Choudhury and he agreed to assume care since Bass didn't have privileges at DSH.

- Berliner reports that he was advised that Dr. Choudhury had not been advised either verbally or in writing concerning the complications that Dr. Bass had with his two operations on Patient A.

2. Letter from Dr. McGregor dated 9/9/91 (Appellant's App., pp.1-4)

- Dr. McGregor reviews records supplied him by BME.

* He finds no malpractice in Dr. Bass' care, but states if the BME can get a statement from Choudhury that misrepresentation was made then his position might be different. Dr. McGregor remembered reviewing the discharge summary. (Appellant's Appendix, Vol. II, p. 337).

- Patient A's Medical Records at Desert Springs Hospital are materially

changed on 9/11/91. (New Discharge Summary dictated).

- Dr. McGregor is the only physician who **may** have seen unaltered records or records which had fewer alterations and deletions. . Therefore, his finding of no malpractice on Dr. Bass' part is significant.

3. BME destroys medical records relied upon by Dr. McGregor's well as the notes of Dr. McGregor's review.

4. Hearing before BME

- Bass' motion to recuse BME for its bias and prejudice denied immediately after filing. Subsequent Petition for Judicial Review and Writ to this Court provide no relief despite there being no procedure in place concerning the consideration of this type of motion.

- Prehearing depositions prohibited.

- Bass' counsel received from BME incomplete medical records concerning Patients A and B just days before the hearing.

- Bass provided subpoenas just days before commencement of hearing.

- Dr. Bass' counsel obtains the testimony of all of the reviewers concerning Patient A and everyone without exception says based upon the description in Dr. Choudhury's operative report, that

they would had done a diverting colostomy.

- Dr. Gardner stated: "I would have done a colostomy. But the autopsy showed he got away with a simple repair."Volume 9, p. 4-82, of Transcript.

- In essence, Dr. Gardner only reviewed Dr. Choudhury's actions from the prospect of luck and assumed that he was accurately describing what he saw. No one from the BME examined the records to see whether or not Dr. Choudhury's report was falsified.
- Dr. Bass' subpoenas quashed by Hearing Officer.

- Incomplete records submitted as the true "certified" records were the basis for all expert testimony against Dr. Bass.

5. Evidence Ignored by BME that Dr. Choudhury's Operative Report is Falsified

- The findings of the preoperative cat scan contraindicate the abdominal operation. [These are the cat scans removed from records and reports found in Dr. Plon's car trunk]

- Operative photos are inconsistent with description provided by Choudhury in his operative report.

- No experts had seen the operative photos--photos not available for review -

Reviewers relied on Dr. Choudhury's description exclusively.

- Intra-Operative report and anesthesia report do not support Dr. Choudhury's operative report--there is no mention of colon injury nor necrotizing fascitis.

- Pathology does not support the operative report.

- 7/21 consult of Dr. Bierbaum, plastic surgeon, finds fascia intact - contradicting finding of necrotizing fascitis.

- The specimen that Dr. Choudhury took after first operation intended to document the necrotizing fascitis turned out to document normal fat.

- Dr. Choudhury's 2nd operation to address his concern about necrotizing fascitis also resulted in specimen sent to pathology. It turned out to be a well-formed blood clot.

- The autopsy report made no findings of necrotizing fascitis

- The pathology at the time of the first operation on 7/20 /90 on the specimen of small bowel removed reflected no leakage - contradicting Choudhury operative report of "freely leaking".

- The BME did not call Dr. Choudhury to testify even though they based their entire case on him. It is obvious that the BME knew, when they didn't call him, his testimony would be adverse to them. Subsequent testimony by Dr. Choudhury revealed that he was informed by Dr. Bass that Dr. Bass' examination at approximately 5:00 a.m. on 7/20/90 showed a "stable abdomen"with acute change in lungs. The medical records created at Women's Hospital were not reviewed by Dr. Choudhury until two years after the patient's death. Therefore, he did not even **look** for the results of tests ordered by Dr. Bass. This type of conduct is clear gross malpractice.

IN THE SUPREME COURT OF THE STATE OF NEVADA
Filed August 07 2000
Case No. 30632

HARRISTON LEE BASS, JR., M.D.,)
Appellant/Cross-Respondent,)
vs.)
STATE OF NEVADA, BOARD OF)
MEDICAL EXAMINERS,)
Respondent/Cross-Appellant.)
)

HARRISTON LEE BASS, JR., M.D.'s PETITION FOR REHEARING RE: ORDER OF REVERSAL ON CROSS-APPEAL AND ORDER DISMISSING APPEAL

COMES NOW, HARRISTON LEE BASS, JR., Appellant/Cross-Respondent, , by and through his attorney, R. PAUL SORENSON, and files his Petition for Rehearing Re: Order of Reversal on Cross-Appeal and Order Dismissing Appeal entered on June 1, 2000.

Introduction

The most significant misapprehension of the Court is contained in the Court's conclusion of their Order of Reversal on Cross-Appeal and Order Dismissing Appeal, which states:

> We conclude that the procedures employed by the Board did not erroneously deprive Dr. Bass of his due process rights, and that additional or substitute procedural safeguards wouldhave been of no value given the length and comprehensive nature of the proceedings. Indeed, Dr. Bass received a

> **copy of all medical records and expert reports prior to the hearing,** presented evidence, and examined/cross-examined some thirty-two witnesses. Further many months later, Dr.Bass was given the opportunity to cure **any** deficiencies perceived in the record of the first hearing. (Pages 21 and 22 of the Order of Reversal on Cross-Appeal and Order Dismissing Appeal, emphasis provided)

This conclusion is a misstatement of the record commencing with the first conclusion that Dr. Bass received a copy of all medical records and expert reports prior to the hearing. Dr. Bass still has not received all medical records. Dr. Bass received a small portion of the records in the afternoon of June 28, 1993 (public complaint was filed June 6, 1992, Appellant's Opening Appendix, Vol. 1, pgs 5-11). The hearing commenced on July 6, 1993 (Reporter's Transcript of Proceedings, July 6, 1993, Vol. I, p. 4) No expert reports (other than one affidavit of Dr. Choudhury) were received prior to the commencement of the hearing.(Reporter's Transcript of Proceedings, July 6, 1993, Vol. 1, p. 3).

This court also overlooked or misapprehended the procedural significance of the peer review conducted by the State of Nevada Board of Medical Examiners. This procedure is used to determine probable cause or weed out non-meritorious claims prior to a public complaint being filed against the physician (98% of claims are dismissed at this point,. In addition, this ccurt misapprehended the fact that the first peer review conducted at the behest of the Board of Medical Examiners (Dr. McGregor's) found no malpractice by Dr. Bass with regard to Patient "A". The Court further overlooks or misapprehends that

records were then changed **after** that peer review and those falsified records are the same records being used by the Board of Medical Examiners and all reviewers subsequent to Dr. McGregor. This Court also overlooks the fact that the peer review of Dr. McGregor was not given to Dr. Bass prior to the proceedings, but was only disclosed by the Board of Medical Examiners after the hearing actually commenced. The Court further overlooks the fact that the Board of Medical Examiners should have been aware that the records were altered after Dr. McGregor's review, but hid the alterations from Dr. Bass and they continue to claim they don't exist.

Because Dr. Bass was denied a complete copy of medical records and prehearing discovery, discovery had to be conducted at the time of the hearing without any chance to have the review and reflection prehearing discovery affords, such as having an expert review the records because records were being subpoenaed by Dr. Bass on a daily basis to attempt to fill in the gap. The Board of Medical Examiners actively directed the content of the so-called "complete, certified records." (See Board of Medical Examiners, Exhibit 16, Record on Appeal). No inquiry is permitted by the Board concerning that process. As a result, no inquiry can be made by the Respondent of anyone who has knowledge of what was gathered or how it was accomplished. (Supplement to Record on Appeal - Document 8 (Deposition of Charles J. Romanolo.).

Misapprehended or Overlooked Facts
Material Facts that have been
Overlooked or Misapprehended
Re: Patient "A"

1. The Court has overlooked the **peer review finding** of Dr. McGregor made on September

9, 1991, wherein he found **no probable cause** to file a public complaint against Dr. Bass. (Appellant's Opening Appendix, Vol. I, pp. 2-4). (All McGregor's notes and records utilized in his review were destroyed.)

2. The Court overlooked or misapprehended the fact that falsified records were then submitted by the Board of Medical Examiners to new reviewers. The records were **materially altered by adding a "new discharge summary"** (dictated on 9/11/91) **after** Dr. McGregor's finding of no probable cause. The remaining reviewers and witnesses who reviewed records utilized these falsified records to base their opinions upon, utterly lacking the necessary foundation. The discharge summary is the **principal** record utilized by reviewers. In this case, the original "discharge summary" was removed and a new one substituted. (Appellant's Reply Appendix, Vol. II, pgs. 256-258.)

4. The Court further overlooked the fact that Dr. Bass and his counsel prepared and presented to the Board of Medical Examiners on Remand and to the District Court, a document entitled "Five False Scenarios" pointing out questionable entries in the medical records which denotes five separate and distinct attempts by others to falsify the medical records of Patient "A". This was Bass' attempt to simplify the evidence uncovered concerning the falsification of medical evidence. (Appellant's Opening Appendix, Vol. V, pgs. 1054-1137). (This exhibit references to pages of medical records.)

5. The Court overlooked the fact that Dr. Bass' care was interfered with and the complete evidence of that interference is still not available to Dr. Bass despite exhaustive efforts to retrieve the same along with all discovery related to these matters.

(Letter Requesting Change of Venue and Discovery dated 8-18-92, Appellant's Opening Appendix Vol. I, pp. 72-77; Letter of Response to 8/24/92 Letter & requesting Issuance of Subpoenas dated 8-26-92 - Appellant's Opening Appendix, Vol. I, pp. 78-80; Motion for Board to Immediately Produce and Provide Copies of ALL Medical Records Including But Not Limited to X-Rays and Diagnostic Tests filed 6-30-93 - Appellant's Opening Appendix, Vol. I, pp. 172-175; Motion to Compel Compliance with Order Entered 6-16-94 filed 8-15-95 - Appellant's Opening Appendix, Vol. III, pp. 737-745; Motion to Compel Production of All Medical Records and Evidence filed 6-994, Vol. III, pp. 718-727; Motion for Reconsideration of Hearing's Officer's Order with Regard to Discovery filed 6-30-93 - Appellant's Opening Appendix, Vol. I, pp. 199-203; Motion to Produce Evaluation, Findings and Recommendation of Investigative Committee that was Presented to the Board filed 6-30-93 - Appellant's Opening Appendix, Vol. I, pp. 195-198.

6. The Court limited the offer of proof on remand and further denied the consideration of proof gathered after the remand hearing. (Motion to Supplement Record on Appeal , filed on December 1, 1999 and denied on December 3, 1999)

Material Facts that have been Overlooked or Misapprehended

Re: Patient "B"

1. The Court overlooked or misapprehended affidavit of the pathologist who examined the tissue of the deceased and timed the occurrence of the cecal volvulus and substituted the judgment of themselves an non-expert (Dr. Juell) who

ignored or was not shown the evidence.[23] (Appellant's Opening Appendix, Vol. V, p. 1040)

2. The Court further overlooked or misapprehended the fact that the medical records of Patient "B" up until the time of the cecal volvulus showed a consistent improvement in the patient (Board of Medical Examiners Exhibit 15) and that there was **nothing** in the medical records to support the findings of Dr. Juell that the volvulus occurred before Dr. Bass diagnosed a surgical abdomen and attempted to transfer the patient for purposes of immediate surgery.

3. The Court overlooked or misapprehended the significance of the admit slip (Appellant's Appendix, Vol. V, pp.. 1029-1031) which demonstrated the attempts of Dr. Bass to transfer Patient "B" and further overlooked or misapprehended the **significance** of the **admit slip being removed** from the certified records thereby making the same materially false when presented by the Board to its reviewing physician and at the first hearing of the Board.

4. The Court overlooked the interference in Dr. Bass' care of Patient "B" and ignored the affidavit of Donna Fleming, R.N.-the nurse on duty at the time of the occurrence (Appellant's Opening Appendix, Vol. V, pp. 1046-1051). The Court overlooked the affidavit of Susan Wright, R.N., the nurse on duty the night before the occurrence of the volvulus (Appellant's Opening Appendix, Vol. V, pp. 1052-1053) who stated "I would recall if I or other members of the nursing staff in my hearing had criticized Dr. Bass' treatment

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[23]It should be noted that Dr. Voss' affidavit was not available to Dr. Juell since it was obtained after the hearing.

of a patient and I do not recall such an incident." Instead, the Court accepts the testimony of Dorothy Miller, R. N., who, contrary to hospital rules, made no entries in Patient "B"s medical records, if she in fact made observations about the patient. After all, Dr. Bass is entitled to have her observations as well as all other medical personnel so he can properly care for the patient. This Court on page 16 of it s Order of Reversal states that Dorothy Miller diagnosed a surgical abdomen, however, Dorothy Miller made no entry of that and more importantly is unqualified to make such diagnosis as only physicians can. She was just making a nursing diagnosis. (Respondent's Appendix, Vol. I, p. 179.)

5. The Court overlooked the fact that all of the "peer review" medical records that were made at Women's Hospital and U.M.C. had to contain material evidence concerning the interference with care and the fact that these records were never gathered or examined by the Board of Medical Examiners.

6. The Court overlooked that Patient "B's injury occurred when Dr. Bass was no longer his physician as he was removed from the case by either Women's Hospital, University Medical Center, and/or the family of the patient..

7. The Court limited the offer of proof on remand and further denied the consideration of proof gathered after the remand hearing. (Motion to Supplement Record on Appeal , filed on December 1, 1999 and denied on December 3, 1999)

Argument

This Court, in its Order, cites to the same cases relied upon by Appellant Bass, and therefore, it is obvious that what is in dispute is the application of the facts to Dr. Bass as announced in Mishler v. Board of Medical Examiners, 109 Nev. 287, 849 P.2d

217 (1003)and the other cases cited by Appellant Bass. The Order appears to require verification from Dr. Bass of the alteration of records. Dr. Bass was not in a position of securing and preserving the records as he had no authority. The sole authority rested in the Board of Medical Examiners. They, however, destroyed the records reviewed by their own peer reviewers. To place the burden on the person who has no power to marshal these records is a departure from Mishler, supra.

The District Court, who had the first opportunity to review Dr. Bass' arguments about falsified records, stated as follows:

> THE COURT: If, in fact, it later turns out, of course, that the board did destroy these records or didn't consider these records that might be of benefit to the doctor, any action by the board will be thrown out. So I wouldn't see why the board - -give him anything he needed to defend.
>
> (Appellant's Opening Appendix, Vol. IV, page 778 (Reporter's Transcript of Hearing - 01-10-95).

See also, Appellant's Opening Appendix, Vol. IV, pp. 778-788 concerning the admission by the Board of Medical Examiners of the destruction of the records that were maintained by the individuals doing peer review for a probable cause determination by the Board of Medical Examiners.. It also discusses the failure to gather the peer review materials that were generated by the hospitals at the time of interference with care.

What is interesting in the colloquy between the Court and the then Deputy Attorney General, Page Underwood, is that **she confirms** that the **certified**

records in these cases were **identical** to the records submitted to their peer reviewers like Dr. McGregor, etc., since that was the issue in that argument. What is overlooked is that the new discharge summary, prepared after his review, **could not** have been **available** to Dr. McGregor.

The Board seems to think that it can correct years of damage caused by the falsification by conducting a cursory examination of a portion of falsified records and concluding that those documents which they admittedly destroyed (which are no longer available for comparison purposes) were duplicates or redundant. We need not even consider if falsified records had any input on the judgment of the Board of Medical Examiners' experts. After all, Dr. McGregor found no malpractice.

An exact review of the records uncovered by Dr. Bass, will reveal that virtually none of the records listed by Dr. Bass as falsified in his Opening Brief and Reply Brief are duplicated in the "certified records".

Comparing the facts of Mishler v. State Board of Medical Examiners, 109 Nev. 287, 849 P.2d 217 (1993) and the facts of Dr. Bass' cases reveals a notable difference and that is that Dr. Bass has in fact uncovered a portion of the records removed or inserted to falsify and/or alter the records relied upon by the experts proffering opinions. As indicated in Nix v. Whiteside, 475 U.S. 157, 106 S.Ct. 988 (1986),

> This Court long ago noted: 'All perjured relevant testimony is at war with justice, since it may produce ajudgment not resting on truth. Therefore, it cannot be denied that it tends to defeat the sole ultimate objective of a trial.' *In re Michael*, 326 U.S. 224, 227, 77 S.Ct. 78, 79, 90 L.Ed. 30 (1945). When the Court

has been faced with aclaim by a defendant concerning prosecutorial use of suchevidence, it has "consistently held that a conviction obtainedby the **knowing use of perjured testimony is fundamentally unfair, and must be set aside** if there is any **reasonable likelihood** that the false testimony could have affected the judgment of the jury. (emphasis provided)

Dr. McGregor, with **his set of records**, found **no basis** to file a public complaint against Dr. Bass with regard to Patient "A". It is at this point that 98% of complaints against doctors are dismissed. Falsified records are clearly not the basis for a new review of probable cause and subsequent filing of a public complaint. As stated, in part, in Dutt v. Kremp, 111 Nev. 567 at 575, 894 P.2d 354 when citing Nelson v. Miller, 607 P.2d. 438, 433 (Kan. 1980)::

> "Just as an action for malicious prosecution will lie where a person commences an action without an objectively reasonable basis, an action will also lie where a person wrongfully continues a civil proceeding without probable cause."

Deference to the Board of Medical Examiners with regard to both Patients "A" and "B" will result in a deprivation of due process to Dr. Bass. The Board of Medical Examiners has refused prehearing discovery, has refused to even consider the unrefutable proof that records have been falsified or altered to caste the blame to Dr. Bass. The Board of Examiners has refused to consider the independent testimony offered with regard to Patient "B" that Dr. Bass did in fact

recognize the patient's condition and tried to do something about it but was hindered by the actions of both hospitals. The Board of Medical Examiners has refused to see the significance of the timing of the occurrence of the volvulus in Patient B by the actual pathologist who examined the patient's tissue. The Board of Medical Examiners has refused to see the significance of the admit slip being withheld with regard to Patient "B" documenting Dr. Bass' attempts to transfer the patient and being deny admittance. With all that the Board of Medical Examiners will and has ignored in order to prosecute Dr. Bass, deference should not be given. Their actions are blatantly arbitrary and capricious.

As previously pointed out, the lack of discovery afforded to Appellant Bass, as well as the irregularity in the proceedings conducted against him, denied him due process, guaranteed under the Fifth and Fourteenth Amendments of the United States and Nevada Constitutions. The failure to accord him the same safeguards afforded other physicians also deprived him of Equal Protection.

CONCLUSION

1. The record with regard to Patient "A" shows that there was no probable cause to file a public complaint against Dr. Bass and that subsequent to that finding by Dr. McGregor, the records were materially falsified as set forth above. The medical records reviewed by and relied upon by Dr. McGregor, have been destroyed by the Board of Medical Examiners along with Dr. McGregor's notes. This results in the only possible conclusion: That the complaint against Dr. Bass with regard to Patient "A" must be dismissed as the Board of Medical Examiners does with any other complaint when no probable cause exists.

2. As set forth in the Opening and Reply brief of Dr. Bass, and as set forth in this instant Petition, Dr. Bass pointed out additional evidence of at least five attempts to alter the records of Patient "A". This was submitted to the Board of Medical Examiners who ignored those outrageous falsifications.

3. With regard to Patient "B", Judge Leavitt understood the significance of Dr. Voss' (pathologist) affidavit timing the occurrence of the cecal volvulus and the Affidavit of Donna Fleming - the nurse on duty --clearly presenting that Dr. Bass had already attempted to transfer the patient long **before Dr. Fisher even arrived at the hospital** (Appellant's Opening Appendix, Vol. V, pp. 1046-1051), debunking the theory that only after Dr. Fisher arrived did Dr. Bass appreciate the gravity of the situation. The theory that Dr. Fisher was there before Dr. Bass started his intense efforts to treat and transfer this patient are not supported by the records.

4. The Court overlooks the fact that Dr. Bass had no ability to obtain his own experts prior to the hearing for the simple reason that he didn't have any of the records until 4 to 5 days before the hearing and did not have the Board of Medical Examiners' expert's opinions until after the hearing commenced. The Court further overlooks the fact that since Dr. Bass' counsel was forced to conduct discovery in the middle of the proceedings, no time was available to review the massive materials that were subpoenaed to the hearing.

Substantial justice dictates that this Court grant the rehearing and dismiss the proceedings against Dr. Bass on the entire record or in the alternative to remand the same to an impartial fact-finder to obtain all the remaining medical records and further identify all missing and falsified records,.

Respectfully submitted,

/s/ R. Paul Sorenson
R. PAUL SORENSON
Nevada Bar No. 002124
513 South Sixth Street
Las Vegas, Nevada 89101
Attorney for
Harriston Lee Bass, Jr., M.D.
Appellant/Cross-Respondent.

ATTORNEY'S CERTIFICATE

The undersigned attorney for Appellant/Cross-Respondent certifies that he has read the above and foregoing **HARRISTON LEE BASS, JR., M.D.'s PETITION FOR REHEARING RE: ORDER OF REVERSAL ON CROSS-APPEAL AND ORDER DISMISSING APPEAL**; that to the best of his knowledge, information and belief, said Petition is not frivolous or interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation.

The undersigned attorney further states that the above and foregoing Petition for Rehearing complies with all applicable Nevada Rules of Appellate Procedure, including the requirement of NRAP 28A that every assertion in the brries regarding matters in the record are supported by a referene to the page of the transcript of appendix where the matter relied on is to be found.

DATED this 3rd day of August, 2000.
Respectfully submitted,

/s/ R. Paul Sorenson
R. PAUL SORENSON

Nevada Bar No. 002124
513 South Sixth Street
Las Vegas, Nevada 89101
Attorney for
Harriston Lee Bass, Jr., M.D.
Appellant/Cross-Respondent.

CERTIFICATE OF MAILING

I hereby certify that on the 3rd day of August, 2000, I served a copy of the above and foregoing **PETITION FOR REHEARING RE: ORDER OF REVERSAL ON CROSS-APPEAL AND ORDER DISMISSING APPEAL** by placing a copy of same in the United States Mail, Las Vegas, Nevada, postage prepaid, to:

FRANKIE SUE DEL PAPA
BRIAN KUNZI
Deputy Attorney General
555 East Washington, #3900
Las Vegas, Nevada 89101
Attorneys for Respondent/
Cross Appellant
/s/Sarah S. Higgins
An employee of R. Paul Sorenson

IN THE SUPREME COURT OF THE STATE OF NEVADA

Filed December 1, 1999

Case No. 30632

HARRISTON LEE BASS, JR., M.D., Appellant/Cross-Respondent,

vs.

STATE OF NEVADA, BOARD OF MEDICAL EXAMINERS, Respondent/Cross-Appellant.

MOTION TO SUPPLEMENT RECORD ON APPEAL

COMES NOW, Appellant/Cross-Respondent, HARRISTON LEE BASS, JR., M.D. and pursuant to NRAP 26 moves this Court to permit him to supplement the record on appeal in the above entitled matter by permitting him to supplement the record on appeal with:

1. Affidavits of P. Joan O'Carroll (**Exhibits A and A-1 attached hereto**). **Exhibit A** is a complete analysis of medical records of Patient B. **Exhibit A-1** is an analysis of peer review records recovered to date including a statement of their significance concerning the care of Patients A and B.

2. Affidavit of Dr. Callendar **(Exhibit B attached hereto)**. Dr. Callendar is a surgeon who discusses in this affidavit, the significance of the medical records of Patients A and B as well as his opinion concerning the impact of the missing and altered records.

3. Affidavit of Henry Gong, M.D. **(Exhibit C attached hereto.)** Dr. Gong is an expert pulmonologist including a review of the medical records including the pulmonary consult of Suresh Tawney along with his opinion

concerning the impact of the missing and altered records.

4. **Exhibit E.** This is a typed narrative presented to the peer review committee investigating the care of Patient B. This type narrative was just authenticated by its author, Jacqueline Summers, R. N. on October 21, 1999. Its significance is what it omits, specifically, Dr. Bass' efforts to care for and transfer Patient B. It is referred to in **Exhibit A - Affidavit of P. Joan O'Carroll** in Paragraphs 14-19.

These affidavits are attached and should be supplemented to the record on appeal of this matter for the reasons set forth in the Points and Authorities filed herewith.

/s/ R. Paul Sorenson
R. PAUL SORENSON
Nevada Bar No. 002124
513 South Sixth Street
Las Vegas, Nevada 89101
Attorney for Appellant/
Cross Respondent BASS

POINTS & AUTHORITIES

Appellant/Cross-Respondent Bass brings this Motion pursuant to NRAP 27 which states in part as follows:

> **(a) Content of Motions; Response; Reply.** Unless another form is elsewhere prescribed by these Rules, an application for an order or other relief shall be made by filing a motion for such order or relief with proof of service on all other parties.

The attached affidavits were obtained after briefing was closed in this matter. The significance of these affidavits is they all address

the difficulties caused by the records problem in these cases. Dr. Bass had previously moved for funds for experts before going forward with the hearing which commenced in July of 1993. That motion along with several others of Dr. Bass was summarily denied by the Board of Medical Examiners through their Hearing Officer. Only after some time of gathering the funds to be able to conduct some of the reviews that the State of Nevada should have conducted, has Dr. Bass been able to obtain these opinions. In the case of Dr. Callendar, after long search for such an expert, Dr. Bass was able to obtain the opinion of an old professor who did not expect or request any funds for his opinion and review.

These affidavits put to rest the argument that there are no missing or tampered with records. It is Dr. Bass' claim that if the Board of Medical Examiners, their counsel, and the hospitals had followed the orders of Hearing Officer Legarza (Appellant's Appendix pp. 296-303) and the orders of Judge Leavitt (Appellant's Appendix pp. 741-743) we would not be where we are today. Justice requires the consideration of this additional documentation. In Barrett v. Baird, 111 Nev. 1496, 908 P.2d 689, this Court stated, in part, as follows:

> NRCP 59(a)(2) provides that a new trial may be granted due to misconduct of the prevailing party. A new trial based upon the prevailing party's misconduct does not require proof that the result would have been different in the first trial without such misconduct. The United States Supreme Court has held that the litigant whose counsel has engaged in misconduct is not entitled to "the

benefit of calculation, which can be little better than speculation, as to the extent of the wrong inflicted upon his opponent." Minneapolis, St. Paul & Sault Set. Marie rec., v. Moquin 281 U.S. 520, 521-22 (1931). Nevertheless, '[t]o warrant reversal on grounds if attorney misconduct, the 'flavor of misconduct must sufficiently permeate an entire 'proceeding to provide conviction that the jury was influenced by passion and prejudice in reaching its verdict." Kehr v. Smith Barney, Harris Upham & Co., Inc., 737 F.2d 1283, 1286(9th Cir. 1984) (quoting Standard Oil of California v. Perkins, 347 F.2d 379, 388 aforementioned incidents of misconduct permeated the entire proceeding such that the jury was improperly influenced in reaching its verdict. Time and time again respondents' lawyers pushed the limits of propriety.

Accordingly, we reverse the district court's judgment and award of attorney fees.

Attached as **Exhibit "D"** is a copy of a letter from the then deputy attorney general in charge of this case. In spite of the orders of both the Hearing's Officer(Appellant's Appendix pp. 296-303) and the District Judge, Judge Myron Leavitt (Appellant's Appendix pp. 741-743) to produce these materials, she basically states as follows:

This correspondence is in response to your letter dated April 11, 1995. Regarding your request for

> copies of peer review records, the Board has never requested, never obtained and has never had possession of such records. Furthermore, it is my position that the Board has no "duty" to gather such material, inasmuch as such information was totally irrelevant to the Board's case.

It is this type of nonchalance about securing and obtaining these records that has put us where we are today: The Board is defending the record on tainted and incomplete records and Dr. Bass is still attempting to fill in the gaps using whatever limited resources he has. To accomplish this, he has obtained the attached affidavits which he would request to be supplemented to the record herein. Those affidavits all address the critical problem of the records.

Respectfully submitted,
/s/ R. Paul Sorenson
R. PAUL SORENSON
Nevada Bar No. 002124
513 South Sixth Street
Las Vegas, Nevada 89101
Attorney for Appellant/
Cross-Respondent BASS

AFFIDAVIT OF P. JOAN O'CARROLL, R.N.

STATE OF NEVADA)
)ss:
COUNTY OF CLARK)

P. JOAN O'CARROLL, upon being first duly sworn, deposes and says:

1. Affiant is a Registered Nurse, licensed by the States of Nevada and California, a member in good standing in the National Association of Quality Assurance Professional and is Board Certified by the American College of Quality Assurance and Utilization Review Professionals. Affiant previously served as peer review nurse for the State of Nevada and as Area Supervisor, Nevada Professional Standards Review Organization. Attached is a copy of Affiant's Resume. I was asked by R. Paul Sorenson, one of Dr. Bass' counsel to review certain exhibits that were admitted into evidence into the State of Nevada Board of Medical Examiner's proceedings in Case No. 9455 against Harriston Lee Bass, Jr., M.D. These consist of:

> Exhibit Eleven - Records of Womens Hospital - Patient A (Admission 7/17/90 through 7/20/90 transfer to Desert Springs Hospital); Exhibit Twelve - Records of Desert Springs Hospital - Patient A, Volumes One through Six (Admission 7/20/90 through 8/19/90 - demise)

This review included reviewing the office records of Harriston Bass, Jr., M.D.(Exhibit 10 of BME proceedings) relating to his care of Patient A as well as the office records of Marina Plon, M.D. which were produced at the BME hearing (part

of Document 5, Supplement to Record on Appeal filed 2/19/97).

2. I am familiar with the standards of the Joint Commission on Accreditation of Healthcare Organizations (hereafter referred to as"JCAHO")I utilized and referred to such standards in my employment as a quality assurance/risk management director at Lake Mead Hospital Medical Center. Attached to this affidavit is a copy of the Medical Records Standards of JCAHO in effect during 1990. I have reviewed thousands of medical records as part of my professional duties and expertise for the past twenty years.

3. The exhibits referred to above tendered by Desert Springs Hospital and Womens Hospital were certified by those hospitals as "true and complete". Those certifications are simply not true. Medical records are defined by Nevada law as follows:

NRS 52.320(2) states:

> 'Medical records' includes bills, ledgers, statements and other accounts which show the cost of medical services or care provided to a patient.

NAC 449.379 states:

Hospitals; Medical records.

> 1. A medical record must be maintained for every patient admitted to a hospital.
>
> 2. Records must be permanent, either printed, typewritten or legibly written. All records must be kept in conformity with recognized standards. Medical histories must be retained

for 25 years and may be microfilmed after 3 years if stored on rolls. Emergency room and outpatient records may be microfilmed after 1 year. If unitized jackets or cards are used, microfilming may be done at the time of discharge. Evidence of compliance with these requirements must be demonstrated to the health division.

3. If applicable, records must include the following:

(a) Patient's name.
(b) Address at time of admission.
(c) Date of birth.
(d) Sex.
(e) Social security number.
(f) Marital status.
(g) Date of admission.
(h) Name, address and telephone number of person or agency responsible for patient.
(i) Name of attending physician.
(j) If patient is a minor, name and address of parent or guardian.
(k) Diagnosis upon admission.
(l) Race.
(m) Religion.
(n) State and county of birth.
(o) Progress notes by physician.

(p) Chief complaint.

(q) Consultations.

(r) Nurse's notes which must conform with statute of limitations.

(s) Citizenship.

(t) Orders for medication and treatment.

(u) Orders for diet.

(v) History and physical examination.

(w) Condition and diagnosis of patient at time of discharge.

(x) Place where discharged.

(y) Laboratory reports of all tests completed.

(z) Reports of all X-rays completed.

(aa) Complete surgical record, including anesthesia record, preoperative diagnosis, operative procedure and findings, postoperative diagnosis and tissue diagnosis on all specimens surgically removed.

(bb) Complete obstetrical record, including prenatal, labor, delivery and complete newborn record including birth certificate, test results and the general condition of the baby on discharge.

(cc) Copy of death certificate.

4. Records must contain sufficient information to justify the

diagnosis, warrant treatment and vindicate the end results.

Only members of the medical and house staff may write or dictate medical histories and physical examinations. Records must be authenticated and signed by a licensed physician.

5. Current records as well as those on discharged patients must be completed promptly. Current records must be completed within 24 hours following admission. Records of discharged patients must be completed within 15 days following discharge.

4. The records of Womens Hospital prepared by Dr. Bass are in compliance with JCAHO standards. The remaining records at Womens Hospital and the records of the patient at Desert Springs Hospital which I have reviewed are among the worst that I have ever examined in regard to conformity with JCAHO standards. In my professional opinion, the records tendered and certified as "true and complete" by those hospitals could not have been in such poor condition and been certified without active participation or collusion by a person or persons in the administration of both hospitals. I came to that conclusion for the simple reason that the hospital was submitting copies of the records to the State Board of Medical Examiners, to attorneys and to the Nevada Peer Review Agency. This record would not be submitted without the Discharge Summary as it is one of the most critical documents relied upon by peer reviewers when examining records retrospectively.

5. One of the primary duties of a quality assurance professional such as myself is to identify when there are medical/legal problems and at that point insure that the records are doubly secure. The original records should not leave the doubly secure area under any circumstances and people making requests for records should only receive copies thereof that are certified by assigned and qualified records personnel.

6. As this case was identified as a medical/legal problem very early, it was imperative that the records be doubly secure at that time and in this regard the following is a list of the most serious violations I have discovered in my review:

(a) It was reported to me that some original records belonging to Womens Hospital were found in the records of Desert Springs Hospital and not in the records of Womens Hospital. This should not occur under any conceivable circumstances.

(b) The records of Marina Plon, M.D. at Womens Hospital are seriously deficient in that she failed to appropriately record her observations of the patient:

(i) The records at Womens Hospital showed a marked worsening in the condition of the patient around the time of the placement of the CVP line (8/19/90 @ 3:00 p.m.) while under the care of Dr. Plon. No

progress note was recorded at that time by Dr. Plon.

(ii) Dr. Plon in fact ordered an echocardiogram at that time (8/19/90 @ 4:00 p.m.) but there is no order, written or verbal, and she did not document her reasoning or the findings in the medical record.

(iii) The records of Womens Hospital reflect no indication that Dr. Plon attempted to advise Dr. Bass of the serious change in the patient at this time when she inserted the CVP line.

(iv) There is no indication that Dr. Plon sought any additional consult concerning the change in condition of the patient's lungs immediately after insertion of the CVP line.

(c) That it appears from certain records in Desert Springs Hospital that Dr. Plon did in truth have a working diagnosis of myocardial infarction but no results of cardiac enzymes ordered "stat" can be found in the laboratory records and there is no documentation of the diagnosis to be found in the physician's progress notes in- neither Women's Hospital's nor Desert Springs Hospital's records.

(d) The records at Desert Springs Hospital show

the following extremely serious deficiencies:

(i) The original History and Physical dictated by Dr. Plon has either been intentionally removed or inadvertently lost from the time of admission on 7/20/90 until a replacement was re-dictated on 12/12/90.

(ii) The original Discharge Summary is missing. If it was prepared as required by NAC 449.379, then the record has been intentionally removed or lost and replaced by a new Discharge Summary on 9/11/91 without explanation. (13 months after the patient expired). There is also a page of that new Discharge Summary missing from the records.

(iii) Physicians' Progress Notes, Orders and Consults of Drs. Plon, Choudhury and Tawney are not timed. (7/20/90)

(iv) The medical records document the presence of Dr. Choudhury on admission of the patient (7 a.m. on 7/20/90), however, the record of his examination of the patient and required progress note is missing.

(v) That I have been advised that the records
from Womens Hospital were not present prior

to the operation on the patient by Dr. Choudhury on 7/20/90. At that time it was the custom and practice in Las Vegas, Nevada to transfer the records with the patient.

(vi) As I mentioned above, certain original records of Womens Hospital do appear in Desert Springs Hospital records. The notes from Womens Hospital that appear in Desert Springs Hospitals records have no indication when they were received by Desert Springs Hospital and were inserted in the records. This would represent an attempt at falsification by their insertion in the records sequentially, without an appropriate notation when they were received. This is a violation of NAC 630.230.

(vii) There are other numerous violations of JCAHO standards in the record.

7. Based upon my knowledge and experience as a Quality Assurance professional and my review of the records as set forth above, it is my opinion that the records of the hospitals were not prepared in accordance with JCAHO standards nor with any acceptable community standards and as a result the integrity of the record is severely compromised. The records, other than those prepared by Dr. Bass, would not be reliable for review by responsible physicians attending to the care of

Patient A or rendering opinions as to the quality of the care rendered to Patient A.

8. Further affiant sayeth naught.

/s/ P. Joan O'Carroll, R.N.
P. JOAN O'CARROLL, R. N.

SUBSCRIBED and SWORN to before me this 28th day of April 1997.

/s/ Sarah S. Higgins
NOTARY PUBLIC in and for said County and State

NOTARY PUBLIC STATE OF NEVADA
COUNTY OF CLARK
SARAH S. HIGGINS
My Appointment Expires
May 11, 2000

AFFIDAVIT OF P. JOAN O'CARROLL, R.N.
Re: Peer Review Records

STATE OF NEVADA)
)ss:
COUNTY OF CLARK)

P. JOAN O'CARROLL, upon being first duly sworn, deposes and says:

1. Affiant is a Registered Nurse, licensed by the States of Nevada and California and is a Diplomat of the American Board of Quality Assurance and Utilization. Affiant previously served as peer review coordinator for the State of Nevada as Southern Nevada's Area Supervisor. Attached is a copy of Affiant's Resume'.

2. I am familiar with the Joint Commission on Accreditation of Healthcare Organization (J.C.A.H.O.) standards. I utilized and referred to such standards regularly in my role as Director of Patient Care for Lake Mead Hospital Medical Center, with responsibility for the hospital-wide activities in Quality Assurance, Risk Management and the Utilization of resources. This encompassed the screening of appropriateness of Admissions, Discharges and Transfers to other acute care facilities. The Director of Medical Records reported to me directly. All Incident Reports were directed to my office and I was heavily involved with the Physician Peer Review process and was a member of all standing committees. It was my job to keep the physicians abreast of all

new legislation relating to the care and disposition of the patients, including their responsibility to indigent patients. I was involved in all the legal aspects of Risk Management and communicated regularly with the hospital's legal counsel.

3. That I have been retained by Attorney R. Paul Sorenson to review the medical records of Patient A (Violet Blanchard) and Patient B (William Tryon). I have heretofore executed two affidavits concerning those reviews.

4. I have been further asked by Mr. Sorenson to set forth in affidavit form the basic requirements of peer review; how the peer review process works; the goals of peer review; and further set forth what evidence is customarily contained in peer review records.

5. That the selection of the "peers" to conduct the ultimate review should be done to insure that its members can be fair and impartial. The goal of peer review is generally not to punish a health care provider but instead to improve quality of medical care.

6. That the Quality Assurance Department of a hospital facility, in general, has the responsibility of gathering the records and assure that a fair presentation is made to the members of the peer review panel.

7. Members of the Quality Assurance Department should be well-schooled in the appropriate standards and requirements for

recordkeeping. In general, most physician advisors and members of the peer review panel do not have sufficient time to analyze the records for completeness and thus rely upon the Quality Assurance Department.

8. Any peer review conducted relative to Patients A and B should contain a very careful analysis of the medical records of these patients as this is the prime source of information that is available to the peer review panel.

9. The peer review materials concerning both Patients A and B should contain evidence concerning the interference of care as well as a record of what evidence was available and reviewed or not reviewed. The entire record in any meetings should be reviewed completely including any discussions preceding the actual determination by the panel as hospitals and the peer review process can be and is frequently infiltrated by politics and bias.

10. Although Dr. Bass received some of the peer review materials concerning Patient B, I have reviewed the same and found them to be incomplete. Additionally, I observed that the tape recordings of the meetings are missing and have possibly been destroyed. This seems highly irregular under the circumstances of that case.

11. The peer review records concerning Patient A have not been provided as yet. These peer review records at both Women's Hospital and Desert Springs Hospital should contain material and vital medical evidence concerning the care of this patient and would hopefully shed light on the materially altered medical records in this case. These records should also contain material evidence concerning the interference of care concerning this

patient.

12. That in view of the fact that these peer review records usually contain all of the vital records, it is incomprehensible that the State of Nevada Board of Medical Examiners would not had first secured that information prior to bringing any disciplinary action, particularly in cases such as these concerning Patients A and B when there is a dispute as to the completeness and accuracy of the "certified" medical records.

/s/P. Joan O'Carroll, R.N.
P. JOAN O'CARROLL, R.N.

SUBSCRIBED and SWORN to before me
this 26 day of February 1999.
/s/ Sarah S. Higgins
NOTARY PUBLIC in and for said
County and State

Notary Public - State of Nevada
County of Clark
Sarah S. Higgins
My Appointment Expires May 11, 2000

AFFIDAVIT OF P. JOAN O'CARROLL, R.N.
Re: Review of William Tryon matter

STATE OF NEVADA)
)ss:
COUNTY OF CLARK)

P. JOAN O'CARROLL, upon being first duly sworn, deposes and says:

1. Affiant is a Registered Nurse, licensed by the States of Nevada and California and is a Diplomat of the American Board of Quality Assurance and Utilization. Affiant previously served as peer review coordinator for the State of Nevada as Southern Nevada's Area Supervisor. Attached is a copy of Affiant's Resume'.

2. I am familiar with the Joint Commission on Accreditation of Healthcare Organization (J.C.A.H.O.) standards. I utilized and referred to such standards regularly in my role as Director of Patient Care for Lake Mead Hospital Medical Center, with responsibility for the hospital-wide activities in Quality Assurance, Risk Management and the Utilization of resources. This encompassed the screening of appropriateness of Admissions, Discharges and Transfers to other acute care facilities. The Director of Medical Records reported to me directly. All Incident Reports were directed to my office and I was heavily involved with the Physician Peer Review process and was a member of all standing committees. It was my job to keep the physicians abreast of all

new legislation relating to the care and disposition of the patients, including their responsibility to indigent patients. I was involved in all the legal aspects of Risk Management and communicated regularly with the hospital's legal counsel.

3. I have reviewed the records of Harriston Bass, Jr., M.D. relating to his care of patient William Tryon while he treated him at Womens Hospital. Dr. Bass' records of his care of the patient comply with the JCAHO standards. I have also reviewed the following records concerning the care of William Tryon:

(a) Testimony of Dr. Sheld before the Board of Medical examiners on July 9, 1993 and July 20, 1993;

(b) Testimony of Dr. Follmer before the Board of Medical Examiners on September 9, 1993;

(c) Minutes of the Women's Hospital Ad Hoc Committee meeting held on August 27, 1992;

(d) Minutes of the Women's Hospital Special Executive Committee meeting held on September 3, 1992;

(e) Transfer/Admit Slip of University Medical Center;

(f) Affidavit of Susan Wright, R.N. (nurse treating Mr. Tryon);

(g) Affidavit of Donna Fleming, R.N. (nurse treating Mr. Tryon);

(h) Affidavit of Dr. Voss, Pathologist, as well as his pathology report;

(i) Testimony of Ruth Miller, R.N., before the Board of Medical Examiners on September 7, 1993;

(j) Testimony of Dr. Wixted, before the Board of Medical Examiners on September 7, 1993;

(k) Testimony of Burton Rosenberg, former Administrator of Women's Hospital before the Board of Medical Examiners on September 8, 1993;

(l) Testimony of Marjorie Sheld, R.R.A. before the Board of Medical Examiners on September 15, 1993;

(m) Testimony of Ruby Ann Clare before the Board of Medical Examiners on September 17, 1993 and her deposition testimony on January 9, 1995;

(n) Testimony of Dr. Barry Fisher before the Board of Medical Examiners on September 7, 1993;

(o) Correspondence including letters to the National Practitioner Data Bank, along with Exhibits A - W attached to counsel's correspondence to the National Practitioner Data Bank;

(p) Mercy Ambulance transport record to University Medical Center dated 8/27/92;

(q) Transport records to Women's Hospital dated8/25/92;

(r) Women's Hospital Medical Staff Bylaws, Rules and Regulations in effect at the relevant times of this matter;

and

(s) Affidavit of Dr. Patrick Tripe.

4. I have also reviewed the records tendered by Womens Hospital and University Medical Center as purported copies of the records of William Tryon that were certified by the hospitals involved as "true and complete"

5. The records of Womens Hospital prepared by Dr. Bass are in compliance with JCAHO standards.

6. One of the primary duties of a quality assurance professional such as myself is to identify areas where there are medical/legal problems and at that point to insure that the records are in a more secure area and that the original records do not leave that secure area under any circumstance and that people making requests for records only receive copies thereof that are certified by qualified medical records personnel, and that on-site review of the medical record by persons involved in the care must take place in full view of the

Medical Records personnel.

7. Based upon my knowledge and experience as a Quality Assurance professional and my review of the records as set forth above, it is my opinion that the records of the hospitals as set forth above were not prepared in accordance with JCAHO standards nor with any acceptable LOCAL standard and as a result, responsible physicians attending to the care of Violet Blanchard or responsible physicians rendering opinions as to the care of Ms. Blanchard could not rely on the integrity of the medical record.

8. I note in my review of the materials listed above that upon readmission of William Tryon to Women's Hospital that Dr. Sheld was advised of the readmission--which would be the policy as any time a patient is readmitted following an outpatient surgery it triggers a review by Quality Assurance to establish whether or not the readmission was related to the initial surgery. Under these circumstances, it would have also been appropriate to refer the case to Dr. Sheld as it would be his responsibility on behalf of the hospital, as a Physician Advisor to approach Dr. Bass and suggest a second surgical opinion, if he had any concerns. Peer review is ideally done by a physician in the same specialty. I have specifically noted that even though Dr. Sheld repeatedly indicates his review of Mr. Tryon's chart, neither said

review nor his concerns were ever documented. This documentation is mandatory, particularly in the peer review process to establish objectivity.

9. On August 25, 1992, during the patient's first 24 hours of admission as Women's Hospital, the medical chart reflects that Mr. Tryon received medication four times. On August 26, 1992, he requested medication only **once**. This would indicate the pain was lessening which provides a logical explanation as to why Dr. Bass thought he would soon be able to discharge the patient.

10. On August 27, 1992, Mr. Tryon asked for pain medication at 0215. No pain medication is documented after this. Dr. Voss' affidavit times the occurrence of the cecal volvulus in this patient at approximately the same time that Dr. Bass observed the acute change in his patient's abdomen

11. My review of the materials indicated above reflects that Dr. Bass attempted to transfer Mr. Tryon as early as 7:00 a.m. on 8/27/92. When Lake Mead Hospital Medical Center could not accept the patient, he booked an operating room at University Medical Center at 9:05 a.m. and arranged for Dr. Tate, another Board Certified General Surgeon to receive the patient and assist him in surgery. This was canceled by a phone call from University Medical Center. The last transfer order in the record is at 11:10 on 8/27/92. It is a verbal order by Dr. Sheld assigning the case to Dr. Follmer, the surgeon on call for University Medical Center. Upon my review of the records, it is my

understanding that Dr. Bass had been removed from the case and ordered to leave the building long before that time although the verbal order for transfer includes his name and that of Dr. Sheld..

12. I further meticulously examined the Medical Record entries made around the critical time of the transfer of Mr. Tryon to University Medical Center. There are no nursing entries from 9 a.m. on 8/27/92 at which time the nurse noted that Dr. Fisher was in to see the patient until 11:00 a.m., when there is an entry about the transfer to University Medical Center. This was explained in the affidavit of Donna Fleming, R.N., where she states the chart was not available after Dr. Fisher's consultation at **9:00 a.m.** on that date. This would be the time of Dr. Fisher's dictation of his consultation as he would need the chart for reference to dictate his findings. Dr. Fisher's medical record dictation is recorded at 0926, **8/27/92.** It is particularly interesting that during this critical period for the patient that no flow sheet was kept monitoring his vital signs and medication given, if any. Dr. Bass was removed from the case around this time yet there is no Physician Transfer form signed by the family requesting or giving permission for the removal of the patient's surgeon and transferring care to another surgeon unfamiliar with the patient's history. This is unusual. If it was not done at the patient's request then one would expect to see an Administrative form justifying the removal of the

attending surgeon and the reasons thereof. Documentation of this issue would be mandatory in such a serious incident.

13. My review of the medical records reflect that the postoperative findings indicate the cecal volvulus occurrence was found **not to be related** to the outpatient surgery done on 8/22/92 by Dr. Bass. The medical experts clearly document that fact. Even though it is understandable that some of the reviewing doctors at Women's Hospital might suspect there was a connection to Mr. Tryon's condition on 8/27/92 and his surgery on 8/22/92, my concern is the rush to judgment reflected in the medical and peer review records along with the many inaccuracies found within the Peer Review/Quality Assurance process which directly interfered with the care and delayed crucial treatment of Mr. Tryon during his most critical treatment period along with the removal of the physician who best knew his condition.

14. The time the Ad Hoc Committee meeting held on 8/27/92 at Women's Hospital concerning Dr. Bass was called to order was not noted, however it is noted that it was adjourned at 1900 hours. The taped recording took up over 11 pages, so a reasonable estimate is that it lasted approximately 2 hours, therefore it commenced at approximately 1700 hours.

The first disturbing issue is the typed narrative of the case prepared by the Quality Assurance personnel to take to the meeting and distributed to the members to assist them in their review and assessment of the care rendered by Dr. Bass with regard to the events precipitating the surgical crisis on the morning of August 27th, **there is absolutely no mention of Dr. Bass' attempts to transfer the patient to Lake Mead Hospital and University Medical Center early that morning**. The narrative simply skips on to Dr. Fisher's impressions and his recommendations. There is **no mention** of the **delay**, no mention of the **cause of the delay and** no mention of **the effect of the delay.**

15. The above appears to reflect a deliberate attempt to mislead the reviewing doctors present at the ad hoc meeting and lead them to the wrong conclusions. I am distressed that the full medical record of Mr. Tryon was not copied for each of the members for their review. The members did not have access to the records. It appeared that Dr. Fisher read from the chart when questioned, (pg. 6 of the minutes of the 8/27/92 meeting) "question was asked what he (Dr. Bass) said in the notes" This question is asked by Dr. Lewis (who arrived late at the meeting and was **the only general surgeon present** at the meeting besides Dr. Fisher). Dr. Fisher again stated that he, Dr. Fisher, had arrived at 7:00 a.m. (even though the medical record clearly documents that Dr. Fisher saw the patient at **9:00 a.m.--not 7:00 a.m.** In responding to Dr. Lewis' inquiry, Dr. Fisher stated that Dr. Bass saw the Patient at 6:10 a.m. and Dr. Fisher saw him at 7:00 a.m., thus implying that Dr. Bass had failed to recognize the acute bowel and Dr. Fisher recognized it 40

minutes later. This time of **7:00 a.m.** is reiterated **5 times**.

16. It is my opinion based upon my experience and review that this misstatement of Dr. Fisher resulted in completely misleading Dr. Lewis. Dr. Lewis did not have the chart in front of him, although he should have, and accepted Dr. Fisher's comments as truthful. It is clear from the minutes that Dr. Lewis relied on the misstatements of Dr. Fisher in reaching his opinion concerning Dr. Bass, as he is quoted on page 8 as saying "the most telling thing - I came late, however, all I need to know is that Dr. Fisher saw this man thirty minutes after he was seen by the attending physician. Dr. Fisher said he had an acute abdomen. Dr. Fisher states five times in the hearing that he saw the patient at 7:00 a.m. and is never corrected by others present including the Quality Assurance staff, Drs. Sheld or Wixted who all knew that the chart reflected the time of 9:00 a.m. rather than 7:00 a.m.

17. There is further reference made on page 9 of the 8/27/92 ad hoc meeting minutes to a prior case with which Dr. Bass was involved. Dr. Fisher reflects that it was the same thing and points to a pattern of conduct on Dr. Bass' part. The records reflect that at that time Dr. Wixted moved to suspend Dr. Bass.

18. The conduct of this ad hoc meeting is not objective and beneath acceptable standards and violates their own bylaws concerning such review. As indicated above, the meeting was littered with numerous misstatements and based upon false information. Dr. Bass was wrongfully denied an opportunity to defend the record. There was no attempt to conduct

an objective review of the facts although some members did attempt to ask meaningful questions, the answers given were not supported by the documentation. Peer review is intended to help good doctors to become better doctors. It is not and should never be used as a vehicle to get rid of a doctor or eliminate the competition.

19. A review of the Medical Executive Committee of Women's Hospital on September 3, 1992 reflects a similar lack of standards. Apparently no access was afforded to the original medical record. The tape was apparently turned off again when it came to a discussion of the findings, and according to Ruby Clare destroyed. A good portion of the meeting minutes appears to have disappeared. There are several negative comments about Dr. Bass professionally. This was beneath acceptable standards for review.

20. After reviewing the testimony of Burton Rosenberg, then Administrator of Women's Hospital, I have an additional concern about the conduct of the removal hearings concerning Dr. Bass. It is apparent from the testimony that Mr. Rosenberg had only been at the hospital for about a month and a half at the time of the occurrence. He obviously was not knowledgeable about the strict legalities governing patient transfers between acute care

hospitals, and that University Medical Center could not legally refuse a transfer of a critically ill patient such as Mr. Tryon who required facilities not available at Women's Hospital. This is clearly spelled out in the COBRA law which was passed in 1986. Mr. Rosenberg also indicated in the testimony before the Board of Medical Examiners that he knew Dr. Bass had attempted to transfer Mr. Tryon as early as 8:00 a.m., before Dr. Sheld's attempt. This information was never provided to the Ad Hoc or the Executive Committee. He was present at both meetings but he did not offer any clarification of this critical issue..

21. My review reflects that Dr. Bass did everything within his control to transfer this critically ill patient and that the conduct of Women's Hospital and University Medical Center in both the transfer process and the removal of Dr. Bass from the continued care of his patient was beneath the acceptable standard of conduct in cases of this nature. I believe the conduct itself reflects that it could have been done only for disreputable purposes as the welfare of the patient was clearly overlooked by everyone involved save and except the nurses directly

involved in his care and his personal surgeon, Dr. Bass.

/s/ P. Joan O'Carroll
P. JOAN O'CARROLL, R.N.

SUBSCRIBED and SWORN to before me
this 26th day of February, 1998.

_____
NOTARY PUBLIC in and for said
County and State

AFFIDAVIT OF CLIVE O. CALLENDER, M.D.

STATE OF _____)
)ss:
COUNTY OF _____)

CLIVE O. CALLENDER, M.D., upon being first duly sworn, deposes and says:

A. That I am a duly licensed and practicing medical doctor. I am presently and have been since January 1, 1996, the Chairman of the Department of Surgery of Howard University Hospital. Attached is a copy of my Curriculum Vitae. That I am making this affidavit based upon my own personal knowledge, information and belief as well as based upon a review of the applicable medical records and other evidence .

B. That I first became acquainted with Dr. Harriston L. Bass, Jr., when he was a student at Howard University. That I knew him to be a conscientious and caring individual who was dedicated to practicing his profession on the highest possible plane.

C. I was contacted by Dr. Bass who asked me to assist him by reviewing two medical cases on his behalf for the reason he felt he was being subjected to professional and racial abuse by people and institutions that had an obligation to protect him.

D. That I was further advised by Dr. Bass with regard to both of the medical cases I was to review that his care was actively interfered with by other health care providers and the course of treatment of both patients dramatically **altered** by these interfering providers. Dr. Bass further believed that the

change in the course of treatment may have resulted in the death of his two patients.

E. That upon my review of Dr. Bass' proceedings before the Nevada State Board of Medical Examiners concerning Patients A and B; upon my review of the "certified" medical records presented to the Nevada State Board of Medical Examiners concerning Patients A and B; upon my review of the medical records not included in the "certified" medical records concerning Patients A and B; upon my review of additional testimony, affidavits and evidence concerning the medical treatment of Patients A and B, I have found the following facts and concluded as follows:

PATIENT "A"

1. Dr. Bass was denied access to medical records of the treatment of both patient **A** & B that were made by the interfering health care providers. Incomplete records were provided with the representation under oath that these records were complete at the time of the hearing.

2. Material alterations in the "certified" medical records concerning both cases (Patients **A** and B) were uncovered;

3. That the Board of Medical Examiners admitted to shredding the medical records that their "peer reviewers" had reviewed which reviews were the **basis** for filing a public complaint against Dr. Bass.(these records were gathered very early as the interfering providers filed complaints with the BME).

Medical records were shredded with regard to both Patients **A** and B.

4. That with regard to both Patients **A** and B, the Board of Medical Examiners **did not employ qualified "quality assurance" personnel** to gather, review, analyze and secure

the medical records or if they did Dr. Bass was denied the right to examine that person and further denied access to the evidence gathered by that individual.

5. That the interfering health providers taking over the care of Patients **A** and B failed to review the patients medical records prior to beginning treatment of those patients.

6. That the interfering surgeon subjected **Patient A** to an exploratory laparotomy approximately 12 to 14 hours after he was advised by Dr. Bass orally that the abdomen was stable and in allprobability not the cause of the lung problems. The X-ray taken after CVP insertion(3:00 p.m. on 7/19/90) show "early ARDS" and the X-ray taken after intubation on (4:00 a.m. on 7/20/90) showed "rapid and progressive ARDS". This operation may have removed any chance of survival for this patient and represents,in my opinion to a reasonable degree of medical certainty, gross malpractice on the part of the interfering physicians. **Patient A**'s abdominal catscan with contrast taken just before the surgery referred to immediately above; the operative pathology report; and photos confirm Dr. Bass' examination and findings of the Patient's condition and contradicts Dr. Choudhury's operative report. The abdominal catscan with contrast indicated no leaks and no pathology in the abdomen of Patient A. The operative pathology report revealed no leaks under microscope. No colon injury was documented by the official O.R. records nor by the Anesthesia records. The photos taken interoperatively show a normal post-operative segment of bowel without leaks.

The photos further revealed no pathology.

I further reviewed Dr. Bass' orders, progress notes and transfer orders concerning **Patient A** as well as the subsequent medical records produced at Desert Springs Hospital. It is clear that Dr. Bass' observations and orders were ignored and in fact not even looked at. In my opinion to a reasonable degree of medical certainty this constitutes gross malpractice or possibly criminal activity.

7. That I reviewed all certified medical records produced by the BME, and the records uncovered from Dr. Plon from the trunk of her BMW. The records that were certified as complete and accurate were materially altered and reflect a conscious decision on the part of the people who had control of the records to alter the records in such a way as to cast blame on Dr. Bass. The records that are altered are accurately set forth in the affidavit of Joan O'Carroll.

8. The following represents the irrational occurrences that commenced immediately after Dr. Bass transferred the patient to Desert Springs Hospital and left on his honeymoon:

a. The interfering physicians and Desert Springs Hospital canceled ("pocket vetoed") Dr. Bass's temporary privileges while he was on his honeymoon so that he could not continue care of this patient and further so that Desert Springs Hospital would not have to provide "fair peer review" of the medical events that occurred while Dr. Bass was on his honeymoon. These events are still being hidden along with the evidence gathered during the required investigation (peer review) of these unusual events.

b. The following is a list of medical events that were removed or disguised in the records certified by the medical providers and entities and offered as complete records at the proceedings concerning Dr. Bass by the Board of Medical Examiners:

> **(i)** The catscan report taken just prior to Dr. Choudhury's first operation on 7/20/90 was **missing** from the certified records. The report was retrieved from Dr. Plon's automobile trunk. That report did not indicate the abdomen as the source of the patient's lung problems. That report further revealed that no leaks of the contrast were shown on the X-ray. These findings directly contradict the decision to operate on this patient.
>
> **(ii)** The interoperative photos were **missing** from the "certified records." When the photos were recovered, those photos do not support the conclusions contained in the operative report of Dr. Choudhury. The photographs reflect that Dr. Choudhury operated on healthy post-op tissue with no abscesses or infection. This directly contradicts the operative report.
>
> **(iii)** The pathology of the specimen (**missing** from the certified records), submitted after Dr. Choudhury's first operation (7/20/90) of the small bowel did not reveal any leaks in the small bowel upon gross examination or even upon

microscopic examination. This is in direct contradiction of Dr. Choudhury's operative report.

(iv) The operating room nursing and anesthesia records do not document any colon injury.

(v) The abdominal wall presented no objective evidence of necrosis on photo; pathology (tissue pathology on Choudhury's first operation revealed normal fat and the second operation revealed a blood clot); plastic surgery consult; nor at autopsy.

(vi) The records at Women's Hospital reflected no laser was used on this patient.

(vii) The conclusion by some reviewers that Dr. Bass closed this patient after his open laparotomy and left a leaking bowel is just rank speculation or a blatant fabrication as there is nothing to support that conclusion in the records. This type of conclusion reflects racial or professional bias on the part of those individuals.

(viii) The consults of Drs. Choudhury, Tawney and Speck were done without any of these doctors reviewing the current records of the patient at the time they conducted their consults. In my opinion, to a reasonable degree of medical certainty, these types of consults constitute gross malpractice and are of no value. These records should

be subjected to further scrutiny for other possible misconduct.

(ix) The records created by Desert Springs Hospital are so deficient that it would be extremely helpful to have the same reviewed by additional records experts as there appear to me to be criminal violations in the destruction, removal or alteration of the records.

(x) Dr. Choudhury's decision to operate on Patient **A** with a diagnosis of ARDS is not supported by any records save and except his own self-serving operative report. The mortality rate associated with ARDS is so great that a physician would only operate when absolutely certain of his diagnosis. A second general surgical consult was required and not obtained in this case.

(xi) The operative report of Dr. Choudhury is in direct contradiction of all the **objective** evidence subsequently recovered from the missing records. The reasoning behind these contradictions could be as simple as a desire to cover up gross malpractice. However, this type of conduct deserves very close scrutiny to determine who was responsible for the cover-up and why the records were altered to make the operative report appear plausible. Further clarification and examination of Dr. Choudhury's operative report should be

conducted to determine why that report is inconsistent with the missing records.

(xii) Alteration of records subsequent to the Board of Medical Examiners receiving an opinion of a reviewer (Dr. Byron McGregor--9/9/91) which written opinion found no justification for discipline or censure of Dr. Bass in his treatment of Patient A. The preparation of the discharge summary **after** the issuance of this opinion on 9/11/91 over a year after the death of Patient A (8-19-90) is beneath the acceptable standard of care and is highly suspicious. The fact that the reviewers relied upon by the Board of Medical Examiners and the Board of Medical Examiners itself did not question this requires examination.

9. The undersigned affiant after reviewing the aforementioned materials has considered the following additional questions that should have been raised by the reviewing authorities concerning **Patient "A"** and were not:

a. What is the probability that Dr. Bass closed the patient after he concluded his open laparotomy with a "freely leaking bowel" ? **0%**

There is absolutely nothing in the medical records to support this conclusion and it is distressing to find so-called experts who will so opine but I don't know what records they truly reviewed as the same were destroyed by the Board of Medical Examiners.

b. What is the probability that the patient had a surgical abdomen when she was examined by Dr. Bass at appx 5 - 6:00: a.m. on 7/20/90? **0%**

Again there is absolutely nothing in the record to support that conclusion. A board certified surgeon with the experience of Dr. Bass and the hands on knowledge of this patient was the person best equipped to make the determination that the belly was stable.

c. What is the probability that Dr. Choudhury would make a misdiagnosis when he disregards the opinions of the treating physician and elects a new course of treatment without a review of the immediate medical records? **100%**

Failure to review the medical records is just plain gross malpractice when you are electing to make a dramatic change in the course of treatment. An

unnecessary operation on this patient who already had ARDS substantially increases the risk of death from ARDS.

10. That based upon the review of the records the medical care provided by Dr. Bass was clearly within the national standard of care for physicians of his specialty. The records reflect that Dr. Bass's care was well reasoned and the following represents some areas that I believe show that well reasoned approach to the medical problems facing this patient:

a. Rescheduling the operation when her mental condition may have interfered with recovery.

b. Use of "laproscope" to perform the initial operation. This procedure was not being used by any other surgeons in Las Vegas at that time. It is reported that the use of the laproscope to perform operation in the abdomen produce much fewer adhesions than the open procedure.

c. Promptly and properly performing an "open laparotomy" on the patient (appx 12 hours after concluding the laparoscopic procedure) when the patient developed a "belly wall bleed."

d. Properly had a "Board Certified" surgeon informed and engaged to cover his patient from a surgical standpoint during his short honeymoon.

e. Promptly and properly (4:00 a.m. on 7/20/90) went to Women's Hospital, when he was first advised of her intubation and acute change,

to examine his patient to determine the cause of his patients acute change and further whether it would be safe to leave for a couple of days on his planned honeymoon.

f. Promptly and properly consulted with both physicians covering his patient (5 - 6:00 a.m. on 7/20/90) reporting to them his finding orally and further placing his findings in the records at Women's Hospital. Dr. Bass reported that his examination of the abdomen reflected a stable post operative abdomen. He also advised the physicians of the acute lung change and the need to carefully evaluate the same. The patient was transferred to Desert Springs Hospital by agreement of all physicians with Dr. Bass to resume care when he returned.

PATIENT "B"

1. Dr. Bass was denied access to medical records of the treatment of both patient A & **B** that were made by the interfering health care providers. Incomplete records were provided with the representation under oath that these records were complete at the time of the hearing.

2. Material alterations in the "certified" medical records concerning both cases (Patients A and **B**) were uncovered;

3. That the Board of Medical Examiners admitted to shredding the medical records that their "peer reviewers" had reviewed which reviews were the **basis** for filing a public complaint against Dr. Bass.(these records were gathered very early as the interfering providers filed complaints with the BME). Medical records

were shredded with regard to both Patients A and **B.**

4. That with regard to both Patients A and **B,** the Board of Medical Examiners **did not employ qualified "quality assurance" personnel** to gather, review, analyze and secure the medical records or if they did Dr. Bass was denied the right to examine that person and further denied access to the evidence gathered by that individual.

5. That the interfering health providers taking over the care of Patients A and **B** failed to review the patients medical records prior to beginning treatment of those patients.

6. The interfering health care providers subjected **Patient B** to a delay of 4-5 hours in the performance of an exploratorylaparotomy. Dr. Bass had surgery scheduled to commence at 9:05 a.m. on 8/27/92. This surgery was scheduled by Dr. Bass after he examined the patient and determined that there had been an acute change in the condition of the patient's abdomen. Prior to that acute change Dr. Bass had treated the patient's paralytic ileus in an appropriate fashion well within the standard of care. The medical records of U.M.C. were altered by removing the admission slip prepared contemporaneously by U.M.C. personnel during a call from Dr. Bass to arrange the initial admission and scheduling of surgery of this critically ill patient who had just experienced an acute change to his abdomen. The removal of that medical record memorializing Dr. Bass' efforts to care for his patient amount to an attempt to frame Dr. Bass. A review of the record reflects that the transferring health care providers were labeling Dr. Bass as incompetent as the basis for the interference with care. To

substantiate this, the key record referred above had to be removed. In addition, the expert medical reviewers for the Board of Medical Examiners had to consciously ignore the findings of the pathologist who examined the tissue that was removed from **Patient "B"** when the surgery as finally performed by a substitute surgeon. The pathologist verified that Dr. Bass' observations were correct as to when the acute change occurred and contradicted the assumptions of the interfering health care providers.

7. As borne out by the pathology, the cause of the acute change in the abdomen was the occurrence of a complete cecal volvulus which resulted in a total elimination of the blood supply to the cecum and adjacent intestines. It is my opinion to a reasonable degree of medical certainty that the interference of care and delay of surgery was gross negligence on the part of the inter-fering medical providers.

8. It is also my opinion to a reasonable degree of medical certainty that the delay in surgery caused by the interference of care referred to in Paragraph 7 above, eliminated the last feasible opportunity to correct the damage being caused by the cecal volvulus.

F. That in conclusion, it is my opinion based upon review of all material information that is available at this time concerning Patients **A** and **B**, that the failure of all administrative bodies involved, including the hospitals as well as the Board of Medical Examiners, and the State of Nevada Attorney General's Office to conduct an independent investigation of these

facts can only be indicative of extreme bias, most likely associated with racial issues.

/s/Clive O. Callender,M.D.
CLIVE O. CALLENDER, M.D.

SUBSCRIBED and SWORN to before me
this 5 day of June, 1999.
My Commission expires June 30,2003
/s/ Annie S. Davis
NOTARY PUBLIC in and for said
County and State D.C.

AFFIDAVIT OF HENRY GONG, JR.

STATE OF CALIFORNIA)
)ss:
COUNTY OF LOS ANGELES)

HENRY GONG, JR., upon being first duly sworn, deposes and says:

1. That I am a licensed medical doctor in the State of California specializing in pulmonary diseases and Professor of Medicine, currently practicing at Rancho Los Amigos Medical Center, Downey, California. My qualifications are set forth on my Biographical Sketch, a copy of which is attached hereto and by reference made a part hereof. That I make this affidavit based upon the review of medical records, reports and other material information provided for my review of the care of Patient A (Violet Blanchard).

2. That I have specifically reviewed Exhibit Eleven (Records of Women's Hospital concerning Patient A - Admission 7/17/90 through 7/20/90 until transfer to Desert Springs Hospital; Exhibit Twelve (Records of Desert Springs Hospital concerning Patient A - Admission 7/20/90 through 8/19/90 (Patient A's date of death).

3. That I further reviewed the testimony of Suresh Tawney, M.D., taken at the Board of Medical Examiner's Hearing on 9/10/93 (Pages 8-60).

4. That I also reviewed the Affidavit of P. Joan O'Carroll, R.N. dated April 28, 1998. I also verified the facts as set forth in her affidavit and agree with her conclusions.

5. Additionally, I reviewed available materials from the professional societies dealing with pulmonary and critical care in order to

review guidelines regarding the essential components of appropriate pulmonary consultations. Specifically, the American Thoracic Society has prepared a position papers on "Essentials of a Pulmonary Consultation" (*American Review of Respiratory Diseases* 1987; 136(4); 1065), which sets forth the expected elements of an appropriate pulmonary consultation. This position paper is attached as **Exhibit "A"** hereto.

6. That my professional expectations for an appropriate subspecialty medical consultation consist of the following characteristics:

(i) Reference to physician who referred the consultation.

(ii) Necessity for promptness in response, including date and time of consultation.

(iii) Complete assessment[24] of the referred problem(s).

(iv) Written documentation[25] of medical status of patient,including history, reference to outside medical records (including history, laboratory values, radiographs, etc.), any communication with referring physician, physician examination and review of current laboratory values.

(v) Medical diagnoses or opinions pertinent to the patient's condition, including a

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[24]The assessment should reflect the complexity of the case and the needs of the patient and referring physician.
[25]The documentation should reflect the complexity of the case and the needs of the patient and referring physician.

pertinent review of the differential diagnosis,cognitive discussion of pros and cons, and current limitations in the diagnoses and/or treatment plan. The opinions may differ from the initial diagnoses.

(vi) Salient recommendations for further diagnostic and therapeutic interventions and possible problems or issues. Specialized procedures may be recommended. Literature may be referenced to support decisions.

(vii) Overseeing subsequent care for which you were consulted, depending on the clinical situation and desires of the patient and referring physician.

(viii) Utilize frequent communication with referring physician.

(ix) Teach.

7. The focus of affiant's review is the two-page written Pulmonary Consultation rendered by Suresh Tawney, M.D., dated 7/20/90, regarding Patient A referred to above. My review is based on my knowledge and understanding of the above documents and my professional experience as a pulmonologist who has provided numerous pulmonary consultations, including those in similar clinical situations. The following comments pertain to what is written and subsequently stated by Dr. Tawney and my opinions to a reasonable degree of medical certainty:

A. Pulmonary Consultation by Suresh Tawney, M.D. (7/20/90)

1. Overall, the consultation note is brief and superficial, leaving the reader with medical expertise asking more questions about the patient's clinical status on that date and time (see below).

2. Dr. Tawney's handwriting is not legible (which even he admits to in his 9/10/93 testimony). Although the consultation was "urgent" and required immediate implementation and documentation, a dictated consultation would have been expected which would had made the issue of legibility moot and would have provided clear clinical information. I cannot find a dictation of a pulmonary consultation in the medical records, unlike dictated consultations by other physicians involved in the care of Patient A.

3. Dr. Tawney's note is not timed. Timing is always required but in this case was absolutely essential since the patient was critically ill. The clinical status and ensuing medical decisions may change rapidly in such a setting. Another physician reader may be misled by reading a note written hours before while the patient's condition has changed dramatically.

4. Although, the patient was unable to provide a history, outside medical records and radiographs (i.e., from Women's Hospital) should have been available for all the physicians (including Dr. Tawney) at Desert Springs Hospital to review. Indeed, the outside records should form the basis for any history taken at Desert Springs Hospital. There is no notation by Dr. Tawney about reviewing any outside records. Also, he does not refer to the paramedics' record (Mercy Ambulance) of transfer. Thus, his information in the history is based on an uncertain source(s).

5. The written physical examination is incomplete in several areas. First, the reader cannot determine how sick the patient appears. Generally, physicians indicate their general impression of the patient's overall medical acuity. There is no notation in this important section of the consultation by Dr. Tawney about the patient being intubated (naso-or pro-tracheally?), the number and types of vascular catheters, abdominal or other drains, or other medical equipment. The documented abdominal examination is beneath the standard of care in that there is no mention of drains, surgical sutures, bleeding, crepitations, bowel sound activity, rebound tenderness, etc. Dr. Tawney agreed (9/10/93) that his abdominal evaluation was "incomplete" despite his acknowledgment that he should evaluate the "entire patient" and that "intrabdominal sepsis" was a primary diagnosis.

6. The laboratory data summarized on page two of the consultation does not indicate the date or timing of the results. Again, timing of data is critical in this type of patient (see #1 above). There is no notation about urine output or intake/output of fluids which would be fundamentally important in a patient with progressing fluid and electrolyte abnormalities which would (if not already) affect lung function. Of note is that there is no reference here (or in the medical history) about the laboratory data and radiographs from Women's Hospital. It is mandatory to review these documents and radiographs prior to arriving at a working medical assessment.

7. The assessment section of the consultation is also incomplete and misleading at that juncture in time. The entire section is

very brief and lacks adequate cognitive discussion about the impressions (right or wrong). Based upon the complete medical records, there was a "rush to judgment" in terms of the diagnosis on 7/20/90 by Dr. Tawney for unknown reasons.

For example, why was "sepsis" indicated as the initial diagnosis? Where is the objective evidence? There is no mention of previous positive blood cultures. Dr. Tawney does not indicate at all that the hemodynamic data from the Swan-Ganz catheter support or refute the impression of sepsis. Furthermore, if sepsis is a strong consideration, what is the presumed source? Dr. Tawney indicates an intrabdominal source without sufficient evidentiary discussion. The distention and tenderness of the abdomen could also have been a result of the patient's previous operations. Dr. Tawney also failed to mention the examination conducted by Dr. Bass as documented in Women's Hospital records along with Dr. Bass' report of his exam of the abdomen being stable and the focus should be on the lungs. Dr. Tawney failed to notice or comment on the fact that the records do not contain a lab report concerning the sputum test ordered by Dr. Bass. He further does not comment upon the X-rays that were completed at Women's Hospital prior to transfer along with the notations by Dr. Bass drawing attention to the lung changes as reflected in the X-rays. Dr. Tawney admits to an incomplete abdominal examination (9/10/93). The hemogram (i.e., white blood cell profile) indicates an inflammatory process (such as infection), but does not indicate the source. Infection could have been present in the lungs or urinary tract in this patient, as well as within the abdomen.

In this matter, Dr. Tawney did indicate that "early ARDS" was probable (the chest radiograph at Desert Springs Hospital indicated "bilateral ill-defined alviolar infiltrates"). The pulmonary involvement should have suggested a possible pulmonary source of infection. A differential diagnosis for sepsis was not indicated by Dr. Tawney, but should have been..

The patient had obvious acute respiratory failure and was intubated and mechanically ventilated accordingly. Dr. Tawney suspected "early ARDS" but did not provide a cause except for "secondary to sepsis". Although ARDS is a complication of sepsis, Dr. Tawney did not review the differential diagnosis of the respiratory failure (i.e., ARDS). During his testimony of 9/10/93, Dr. Tawney correctly listed some cause of ARDS, e.g., sepsis, aspiration, trauma, fat embolism, amniotic fluid embolism, pancreatitis. In his testimony on 9/10/93, he did not entertain the possibility of fluid overload or acute myocardial infarction leading to pulmonary edema (although the hemodynamic data did not suggest this). Finally, even massive pneumonia by a number of microorganisms (leading to ARDS) is a possibility. Along these lines, Dr. Plon in her initial admission note suggested pneumonia as a source of infection. This possibility was neither supported nor refuted (i.e., not stated) in Dr. Tawney's consultation note.

Although Dr. Tawney stated that he was "not an expert on ARDS" during his testimony of 9/10/93, he is Boarded in Pulmonary Diseases, a discipline which routinely diagnoses and manages this type of pulmonary condition. Thus, I am surprised and curious as to why he made that statement.

8. The recommendations ("Plan") provided by Dr. Tawney are incomplete. He did not indicate any ongoing communication or dialogue with Dr. Plon or other involved physicians or followup plan. "Surgical reevaluation" is somewhat vague but, his request for abdominal CT scan, and his recorded impressions imply that surgical exploration would be a future possibility. If so, Dr. Tawney should also have indicated the anesthetic and surgical risks associated with the patient's pulmonary and hemodynamic status, particularly in view of this statement "prognosis poor." Dr. Tawney also did not indicate the need for followup chest radiographs, arterial blood gases, fluid management, or non-blood cultures such as of respiratory secretions.

The issue of respiratory cultures was raised during Dr. Tawney's testimony of 9/10/93. Dr. Tawney did not order respiratory cultures because he believed that they would be unhelpful diagnostically (due to ongoing antibiotic therapy) and be contaminated by colonizing organisms. This is beneath the standard of care for physicians of his specialty for the following reasons: Pneumonia must be considered in a patient in this condition, whether or not ARDS is a preceding or subsequent event, since pneumonia is generally diagnosable and reversible. This patient was already intubated (with easy access for respiratory secretions) and could even have had an efficient flexible fiberoptic bronchoscopy with a protected specimen brush (to reduce contamination). Dr. Tawney did not comment on the possible efficacy of a diagnostic bronchoscopy to better diagnose pneumonia, aspiration, etc. Furthermore, no prior sputum

or respiratory cultures were obtained in this patient with obvious pulmonary involvement. The records reflect that Dr. Bass had ordered a sputum test, however, there is no report of the same ever being conducted in the medical records. A positive respiratory culture would have appropriately directed antibiotic therapy (i.e., by changing antibiotics or continuing with the ongoing regimen). In fact, a positive respiratory culture would have been very helpful in the face of sterile blood cultures. Although previous/ongoing antibiotic therapy (even for the incorrect microbiologic diagnosis) may produce negative (sterile) respiratory cultures, it may not necessarily or uniformly show such a result. Only by obtaining respiratory cultures can this issue be resolved in a given patient. Furthermore, this omissive tact of not culturing is beneath the standard of care since physicians are not infrequently "surprised" by the finding of unexpected microorganisms in this setting, such as tuberculosis or fungal infections which are not covered by most (even broad spectrum) antibiotic therapies.

9. In summary, Dr. Tawney has demonstrated deficiencies in his role as an internist and pulmonologist, acting as consultant for a critically ill patient. This opinion is based upon my professional knowledge and experience as an experienced pulmonologist and review of the above documents. The conduct and form of the written pulmonary consultation of 7/20/90 is sub-standard according to medical care in the community and professional guidelines. The pulmonary consultation in question is incomplete, misleading, and inadequate in terms of cognitive discourse of the medical assessment

and recommendations 7/20/90. Dr. Tawney's testimony on 9/10/93 supports my observations regarding his pulmonary consultation. Thus, in my opinion, Dr. Tawney's pulmonary consultation is beneath the standard of care for physicians of his specialty and further scrutiny of this consultation is warranted to determine the reasoning for this obviously incomplete consultation.

B. What was the Cause of ARDS?

10. I was further asked to make a determination to a reasonable degree of medical certainty as to what was the cause of ARDS in Patient A which was the cause of death of Patient A (see Autopsy Report, Exhibit ___.)

11. I reviewed the same materials as set forth in Paragraphs 2, 3, and 4. It is my opinion to a reasonable degree of medical certainty that the cause of ARDS in Patient A was pulmonary aspiration at or about the time of insertion of the CVP line at 3:00 p.m. on 7-20-90.

12. The following is a partial list of the facts supporting my opinions herein which have been gathered from the records I reviewed:

a. Acute change in condition of lungs at time of CVP line insertion from clear to ronchi.

b. Acute change in patient's general condition at the time of CVP line placement from no acute distress to guarded. Patient's vital signs immediately after the CVP line was inserted reflects high stress response characterized by marked increase in respiratory rate and pulse.

c. Trendelberg (head down and feet up position) utilized for insertion of CVP line which can result in the flow of retained acid fluid to go from the stomach into the esophagus and into the lungs.

d. Chest X-ray within 1/2 hour of CVP line insertion shows lungs developing infiltrates when prior X-rays showed atelectasis only. The Radiologist's impression of these infiltrates were early A.R.D.S.

e. Beginning with the insertion of the CVP line, patient showed rapid and progressive deterioration in lung function. She went from the use of a nasal canula to requiring intubation. X-rays and reports thereto at intubation demonstrated rapid progression of ARDS.

f. Immediately upon receipt of transfer at Desert Springs Hospital, the respiratory therapist aspirated large amounts of dark brown, thick fluid from the lungs.

g. Dr. Bass' examination of the patient just prior to transfer reflects a stable abdomen with pulmonary edema, notes to rule out pneumonia, and an order for a sputum culture to be taken.

The sputum culture that was ordered just prior to transfer by Dr. Bass was standard medical procedure. The available medical records reflect that a sputum test was not performed until 8/3/90. The failure to perform the sputum test at the time originally ordered by Dr. Bass upon transfer, or the loss of the result of the test, if it was performed, is beneath the standard of care.

h. The cat scan with contrast of the abdomen taken at approximately 5:30 p.m. on 7/20/90 showed no evidence of the belly as the source of the lung problem. No leaks of contrast from the bowel was shown on the X-rays.

i. The records created by Desert Springs Hospital are so deficient that it would be extremely helpful to have the same further reviewed by specialized records experts as there appears to me to be serious violations in the destruction, removal or alteration of the records.

j. The records at Desert Springs Hospital as certified "complete" by that hospital and utilized by the Board of Medical Examiners are missing **all** of the **chest X-rays and**

the reports thereof for the **first two weeks** of Patient A's admission; as well as the catscan and its report on 7/20/90 and critical lab studies performed on specimens taken after Dr. Choudhury's operation.

k. The records at Desert Springs Hospital as certified "complete" by that hospital and utilized by the Board of Medical Examiners do not contain the ambulance records wherein Patient "A" was transferred from Women's Hospital to Desert Springs Hospital. These records show acute pulmonary edema and the remaining exam was stated as unremarkable.

l. The testimony of Dr. Schlacter, pulmonologist at the hearing before the Board of Medical Examiners reflect that the diagnosis of ARDS was not made until approximately two weeks after admission to Desert Springs Hospital.

In addition, I am advised by Attorney Sorenson that an assertion has been made by the State of Nevada's Office of the Attorney General that the N.G. tube that was in place in Patient A would have prevent aspiration. In this patient, however, her stomach had

been altered in prior operations in such a way that the contents of the stomach could reenter the esophagus. The entrance to the stomach from the esophagus also had alterations. These alterations had been confirmed by previous endoscopic assessment revealing severe erosive esophagitis of the distal half of the esophagus and stomach outlet obstruction.. Because of this, the N.G. Tube would be of limited value in protecting against aspiration.

m. In addition, a hospital certified by J.C.A.H.0 (which I am informed both Desert Springs Hospital and Womens Hospital were at the time of the occurrence) requires that there be peer review by cardiology, infections disease, surgery, pathology, pulmonary and recordkeeping. I am advised that all of these records are being withheld under a claim that they are "confidential". These records are vital parts of the complete medical history of Patient "A" and their access should be permitted. These records would contain material

information concerning this matter and would be extremely helpful and in fact vital to any qualified reviewer.

/s/ Henry Gong, Jr., M.D.
HENRY GONG, Jr., M.D.

SUBSCRIBED and SWORN to before me this 18th day of March, 1999.

/s/ Kenneth W. Clark, Sr.
NOTARY PUBLIC in and for said County and State